DISSERTATION ON

"EFFECTIVENESS OF STRUCTURED TEACHING PROGRAMME ON KNOWLEDGE OF SELECTED POST OPERATIVE SELF CARE FOR PRIMI MOTHERS UNDERGOING ELECTIVE CESAREAN SECTION IN INSTITUTE OF OBSTETRICS AND GYNAECOLOGY AND GOVT. HOSPITAL FOR WOMEN AND CHILDREN, CHENNAI.

M. Sc (NURSING) DEGREE EXAMINATION

BRANCH – III OBSTETRICS AND GYNECOLOGICAL NURSING

COLLEGE OF NURSING

MADRAS MEDICAL COLLEGE, CHENNAI

A dissertation submitted to

THE TAMILNADU DR.M.G.R MEDICAL UNIVERSITY,

CHENNAI – 600 032.

In partial fulfilment of the requirement for the award of degree of

MASTER OF SCIENCE IN NURSING

OCTOBER – 2018

"EFFECTIVENESS OF STRUCTURED TEACHING PROGRAMME ON KNOWLEDGE OF SELECTED POST OPERATIVE SELF CARE FOR PRIMI MOTHERS UNDERGOING ELECTIVE CESAREAN SECTION IN INSTITUTE OF OBSTETRICS AND GYNAECOLOGY AND GOVT. HOSPITAL FOR WOMEN AND CHILDREN, CHENNAI".

Examination	: M.Sc. (N) DEGREE EXAMINATION
Month and Year	: OCTOBER – 2018
Branch and Course	: III-**OBSTETRICS AND GYNECOLOGICAL NURSING**
Register No	: 301621254
Institution	: MADRAS MEDICAL COLLEGE, COLLEGE OF NURSING.

Sd: _____	Sd: _____
Internal examiner	External examiner
Date: _____	Date: _____

THE TAMIL NADU DR. M. G. R. MEDICAL UNIVERSITY

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CERTIFICATE

This is to certify that this dissertation titled, **"Effectiveness of structured teaching programme on knowledge of selected post operative self care for primi mothers undergoing elective caesarean section in Institute Of Obstetrics and Gynaecology and Govt. Hospital for Women and Children, Chennai".** This bonafide work done by **Ms. S. JAYASUTHA.** M. Sc. (N) II year student, College of Nursing, Madras Medical College, Chennai - 600003 submitted to The Tamil Nadu DR.M.G.R Medical University, Chennai in partial fulfilment of the requirements for the award of degree of **Master of Science in Nursing, Branch - III, Obstetrics and Gynaecological Nursing**, under our guidance and supervision during the academic year 2016 – 2018.

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"A STUDY TO ASSESS THE EFFECTIVENESS OF STRUCTURED TEACHING PROGRAMME ON KNOWLEDGE OF SELECTED POST OPERATIVE SELF CARE FOR PRIMI MOTHERS UNDERGOING ELECTIVE CAESAREAN SECTION IN INSTITUTE OF OBSTETRICS AND GYNAECOLOGY AND GOVT. HOSPITAL FOR WOMEN AND CHILDREN, CHENNAI.

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In partial fulfillment of the requirement for the award of degree of

MASTER OF SCIENCE IN NURSING

OCTOBER – 2018

ACKNOWLEDGEMENT

Foremost, I am thankful to **GOD ALMIGHTY** for giving me an ample resilience, exhortation and patronage till the completion of this research work.

I express my genuine gratitude to the **Institutional Ethics Committee** of Madras Medical College for giving me an opportunity to conduct this study.

I wish to express my sincere thanks to **Dr. R. Jayanthi, M.D., F.R.C.P. (Glasg) Dean,** Madras Medical College, Chennai-03 for providing necessary facilities and extending support to conduct this study.

I wish to express my gracious thanks to **Prof. Sudha Seshayyan, M.D., Vice Principal, Member Secretary, Institutional Ethics Committee,** Madras Medical College, Chennai-03 for approval this study.

Extent my earnest gratitude to **Dr. T.K. Shaanthy Gunasingh, M.D., D.G.O., F.I.C.O.G., Director and Superintendent**, and **Dr. S. Shoba, M.D., D.G.O., Deputy Superintendent** Institute of Obstetrics &Gynecology and Govt. Hospital for Women & Children, Egmore, Chennai for her guidance and help extended during the course of the study.

I render my deep sense of sincere thanks to **Dr. M. Thangamani., M.D., D.G.O., Assistant Professor**, Institute of Obstetrics &Gynecology and Govt. Hospital for Women & Children, Egmore, Chennai- 600008 for her valuable suggestions and guidance for this study.

I am deeply indebted to **Mrs. A. Thahira Begum M.Sc. (N)., M.Phil., M.B.A., Principal,** College of Nursing Madras Medical College, for her treasured guidance, highly instructive research mentorship, thought provoking suggestions, prudent guidance, moral support and patience moulded me to make this research study a grand success.

I express my whole hearted gratitude to my esteemed guide, **Former Principal Dr. V. Kumari. M. Sc. (N)., PhD.,** College of Nursing, Madras Medical College, Chennai for guidance, support and encouragement for completing the study.

I am highly indebted to express my deep sense of gratitude to **Dr. M. Mala, M. Sc. (N), Ph. D,** in Child health Nursing**,** College of Nursing, Madras Medical College, Chennai for her constant motivation, support, innovative and creative suggestions towards the successful completion of this thesis.

I immensely extend my gratitude and thanks to **Mrs. V. Vijayalakshmi, M. Sc. (N)., Lecturer,** Obstetrics and Gynecology Nursing, College of Nursing, Madras Medical College, for her valuable suggestions, enlightening of the ideas and for being a sources of inspiration, encouragement, constant support and guidance with patience advice throughout the period of the study. Without her scholarly guidance, it would not have been possible to conduct this study.

I am extremely grateful to **Mrs. S. Thenmozhi, M.Sc. (N),** Lecturer, Obstetrics and Gynecology Nursing, College of Nursing, Madras Medical College, for her encouragement, valuable suggestion, support and advice given in this study.

Extent my special thanks to all the **faculty members** of college of Nursing, Madras Medical College, Chennai for the support and assistance given by them in all possible manners to complete this study.

I express my heartfelt gratitude to the **Nursing Superintendent Grade - I**, Staff Nurses of Gynecology Outpatient department, Institute of Obstetrics & Gynecology and Govt. Hospital for Women & Children, Egmore, Chennai- 600008 for their assistance and help during my data collection.

I gratefully acknowledge the Expert, **Dr. Rosaline Rachel, M.Sc. (N), Ph.D., Principal,** MMM College of Nursing, Nolambur, Chennai – 600 095, and **Dr. Nalini Seeralan, M.Sc. (N). Ph.D. Principal**, Obstetrics and Gynecology Nursing, Sri Ramachandra Medical University, College of Nursing, Porur, Chennai- 600 116 for their valuable suggestions, constructive judgments while validating the tool.

I owe my deepest sense of gratitude to **Dr. A. Vengatesan, M.Sc., Ph.D.,** former **DDME (Statistics), Statistician** for his suggestion and guidance in statistical analysis.

I thank **Mr. S. Ravi, M.L.I.S, Librarian,** College of Nursing, Madras Medical College for his co-operation and assistance which built the sound knowledge for this study.

I thank **Mr. C. Vijayan. B.A., B.Ed., BT Asst. in English,** for editing and providing English content validity.

I thank **Mr. P. Sampath. M.A., B.Ed., BT Asst. in Tamil** for editing and providing Tamil content validity.

I owe my great sense of gratitude **to Mr. Jas Ahamed Aslam**, Shajee Computers, and **Mr. Ramesh**, **B.A**, MSM Xerox for their enthusiastic help and sincere effort in typing the manuscript with much value computer skills and also bringing this study in to a printed form.

My earnest gratitude to all women who admitted in antenatal ward, who had enthusiastically participated in this study without them it was not possible for me to complete this study.

Words are beyond expressions for the supports of my lovable husband **Mr. S. Ravi, Om Shakthi Hardware's,** for his untiring support, consent, encouragement, otherwise this work would not be successfully completed.

At this juncture, it is my privilege to acknowledge the immeasurable pain taking efforts and loving support of my beloved Father **C. M. Saminathan,** Mother **S. Krishnaveni**, father-in-law **Mr. K. Shanmugam,** Mother-in-law **Mrs. Neela Shanmugam,** and all my family members for their encouragement towards the successful completion of my study.

It would be a lapse on my part if I fail to thank my lovable kids **R. Dayakar, R. Mohit** for their patience and cooperation throughout my study.

I am greatly indebted to all my **classmates and friends** who helped me during the course of my study.

My whole hearted thanks and gratitude to all **dear near ones for all their** love, prayers, care, support and encouragement which gave confidence to achieve the goal.

I extend my heartfelt gratitude to those who have contributed directly or indirectly for the successful completion of this dissertation.

I thank the one above all of us, Omnipresent God, for answering my prayers for giving me the strength to plod on during each and every phase of my life.

ABSTRACT

INTRODUCTION: In Asia, postpartum care is considered to be a very importance stage of a woman's life and this belief and practice is passed down through many generations. Experts refer postpartum periods as the first six weeks after childbirth. Primi mothers admitted at IOG expecting normal vaginal delivery but half of them undergoing caesarean section. They have not expected this operative procedure and were unable to perform self care practices during post operative period in regard to perineal care, breast care, newborn care, postnatal exercise, temporary contraceptive methods. So the investigator needs to teach postoperative self care during the antenatal period. So the study was conducted to assess the effectiveness of structured teaching programme on knowledge of selected post-operative self care for primi mothers undergoing elective caesarean section in Institute of Obstetrics and Gynaecology, and Govt. Hospital for Women and Children, Egmore, Chennai-8."

TITLE: " A study to assess the effectiveness of structured teaching programme on knowledge of selected post-operative self care for primi mothers undergoing elective caesarean section in Institute of Obstetrics and Gynaecology, and Govt. hospital for Women and Children, Egmore, Chennai-3."

OBJECTIVE: The study objectives are to assess the level of knowledge on post operative self care among primi mothers undergoing elective caesarean section. To identify the effectiveness of structured teaching programme on selected post operative self care among primi mothers undergoing elective caesarean section. To find the association between post test knowledge on post operative self care among primi mothers undergoing elective caesarean section with their selected demographic variables.

MATERIALS AND METHODS: A Pre-experimental, one group Pretest, Posttest design was conducted. A total of 60 samples were selected by purposive sampling technique. Data were collected from the primi gravida mothers undergoing elective cesarean section using a semi - structured questionnaire before and after the

implementation of the structured teaching program. The data were tabulated and analyzed by descriptive and inferential statistics.

RESULTS: The study result shows, there was a significant difference between the pre-test and post-test level of knowledge regarding post operative self care from 12.58 to 23.47 after the administration of structured teaching programme. Considering overall knowledge score, in pretest primi gravida mothers are having 12.58 score where as in post test they are having 23.47, so the difference were 10.89.The difference between pre - test and post-test score is large and it is statistically significant.

CONCLUSION: Hence, the study concluded the structured teaching programme was effective, appropriate and feasible. It helps the primi mother's to practice self care after caesarean section themselves.

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ABBREVATIONS

WHO	**-**	**World Health organization**
SSC	**-**	**Skin to skin contact**
AAP	**-**	**American academy of pediatrics.**
P	**-**	**Significance**
SD	**-**	**Standard deviation**
CI	**-**	**Class interval**
NICU	**-**	**Newborn Intensive Care Unit**
PCERA	**-**	**Parent – Child Early Relational Assessment**
IOG	**-**	**Institute of Obstetrics and Gynaecology**
STP	**-**	**Structured Teaching Programme**
LSCS	**-**	**Lower Segment Caesarean Section**

CHAPTER - I

INTRODUCTION

"That first pregnancy is a long sea journey to a country where you don't know the language, where land is in sight for such a long time that after a while it's just the horizon – and then one day birds wheel over that dark shape and it's suddenly close, and all you can do is hope like hell that you've had the right shots."

– Emily Perkins

A great responsibility and a highest crown of honour of woman is **Motherhood**. The physiological transition from being pregnant women to becoming a mother means, an enormous change will occur both physically and psychologically. Delivery is not a joyous event in a women's life. It is the time when every system in the body is affected. Though child birth is the normal physiological process and natural, every woman expects normal vaginal delivery.[1]

A caesarean section is necessary when a vaginal delivery would put the baby or mother at risk. This may include obstructed labour, twin pregnancy, high blood pressure in the mother, breech birth, or elderly primi, gestational diabetes mellitus, short primi, problems with the placenta or umbilical cord. A caesarean delivery may be performed based upon the shape of the mother's pelvis or history of a previous caesarean section. . The World Health Organization recommends that Caesarean section be performed only when medically necessary. Some caesarean sections are performed without a medical reason, upon request by the mother.[2]

In Asia, postpartum care is considered to be a very importance stage of a woman's life and this belief and practice is passed down through many generations. In western countries, it is becoming more popular as the women weigh the vast health benefits more than anything else. Experts refer postpartum periods as the first six weeks after childbirth. In real context, postpartum period can stretch up to 4-6 months with the mother herself coping and adapting physically and emotionally after childbirth.[3]

Suwal A., et al (2013). A prospective study was done to compare the maternal and fetal outcome in elective and emergency cesarean section in Nepal Medical College. The incidence of cesarean section was 254 (22.30%), 167 (65.7%) were emergency cesarean section, 87 (34.3%) were elective cesarean section for. The usual indications of emergency cesarean section were fetal distress, previous cesarean section in labour, non progress of labour and prolonged second stage of labour. The usual indications of elective cesarean section were previous cesarean section, breech, cephalo pelvic disproportion and cesarean section on demand. There was found to be no significant difference in age, period of gestation, blood loss and blood transfusion in emergency vs. elective cesarean section. There was significant difference seen in the length of hospital stay, fever, urinary tract infection, wound infection and low APGAR in five minutes indicating that these were more common in emergency cesarean section. The overall complication rate is higher in emergency cesarean section than in elective cesarean section.[4]

The union government has suggested more than 99 percent of births occur in institutions. Tamil Nadu is ranked fifth place of caesarean section deliveries. As per the national family health survey, caesarean section rate in Tamil Nadu,

Telangana – 58 %

Andhra – 40.1%

Lakshadeep – 37.9 %

Kerala – 35.8%

The WHO is restricted 10 % of C-section in the community.[5] Caesarean sections result in a small overall increase in poor outcomes in low-risk pregnancies. They also typically take longer to heal from, about six weeks, than vaginal birth. The increased risks include breathing problems in the baby and amniotic fluid embolism and postpartum bleeding in the mother. Established guidelines recommend that caesarean sections not be used before 39 weeks of pregnancy without a medical reason. The method of delivery does not appear to have an effect on subsequent sexual function.[6]

Postpartum care can be categorized to different categories such as external and internal and mental care. For a new mother, she has to make sure she takes good care of herself in these three aspects during the postpartum period. External care refers to the physical body such as dealing with the change in body shape, coping with breastfeeding problems like engorgement or sore nipples, caesarean incision or even hair loss issues. Internal care refer to things like physical fatigue, body aches, afterbirth cramps, perineal pain or constipation problems. Mental care refer to emotions such as anxiety, impatient, confident level or low esteem due to hormonal changes that trigger us to be more sensitive during postpartum period.[7]

1.1. NEED FOR THE STUDY:

According to World Health Organization (WHO), 2015, The caesarean section is a globally recognised maternal health-care indicator. When caesarean section rates rise towards 10 per cent across a population, maternal and newborn deaths decrease.

In West Virginia (2017), 31 percent of births were C-sections in first-time mothers with low-risk deliveries. In New Mexico, South Dakota and Iowa 17 percent of births were performed as C-sections. The national target of C-sections for low-risk first-time mothers is 23.9 percent or lower. The recent national average rate of C-sections is at almost 26 percent.[3]

The caesarean section rate was significantly lower among tribal compared to the non-tribal women (9.4% vs 15.6%, p-value < 0.01) respectively. The 60% of the differences in the rates of caesarean section between tribal and non-tribal women were unexplained. Within the explained variation, the previous caesarean accounted for 96% (p-value < 0.01) of the variation. Age of the mother, parity, previous caesarean and distance from the hospital were some of the important determinants of caesarean section rates. The most common indications of caesarean section were foetal distress (31.2%), previous caesarean section (23.9%), breech (16%) and prolonged labour (11.2%). There was no difference in case fatality rate (1.3% vs 1.4%, p-value = 0.90) and incidence of birth asphyxia (0.3% vs 0.6%, p-value = 0.26) comparing the tribal and non-tribal women.[8]

Daily 4-6 primi mothers undergoing elective cesarean delivery at IOG. They were unable to perform self-care practices during post-operative period in regard to perineal care, breast care, newborn care, post natal exercise, and contraceptive method. Providing a high standard of care and support to mothers and babies in postnatal period is the responsibility for the health care provider .The proper guidance promotes maternal and neonatal wellbeing by adopting a holistic approach to care and prevent complication like puerperal infection, wound sepsis, neonatal morbidity, and also length of hospital stay after surgery. Women should be offered relevant and timely information to enable them to promote their health and their baby's health and recognize and respond to problems. The postnatal period presents an ideal opportunity for midwives to highlight the importance of postnatal care especially after Caesarean Section. So the investigator needs to teach postoperative self care during the postnatal period, to give proper guideline about puerperal care in the antenatal period.

The average women who had delivered her child by caesarean section will remain the hospital for 4-7 days in the Indian scenario. During this period a number of interventions are necessary to promote healing, prevent post operative complications and establish bonding with the new child. Common concerns of the mother include pain, fatigue, interference with gastrointestinal functioning, reduced activity level etc. it is in this time that the midwife is to be with the mother as a constant support and encouragement and helping her and her family in their needs.

1.2. STATEMENT OF THE PROBLEM.

"A STUDY TO ASSESS THE EFFECTIVENESS OF STRUCTURED TEACHING PROGRAMME ON KNOWLEDGE OF SELECTED POST-OPERATIVE SELF CARE FOR PRIMI MOTHERS UNDERGOING ELECTIVE CAESAREAN SECTION IN INSTITUTE OF OBSTETRICS AND GYNAECOLOGY, AND GOVT. HOSPITAL FOR WOMEN AND CHILDREN, EGMORE, CHENNAI-3."

1.3. OBJECTIVES OF THE STUDY

1. To assess the level of knowledge on post-operative self-care among primi mothers undergoing elective caesarean section.

2. To identify the effectiveness of structured teaching programme on selected post-operative self-care among primi mothers undergoing elective caesarean section.
3. To find the association between post-test knowledge on post-operative self-care among primi mothers undergoing elective caesarean section with their selected demographic variables.

1.4. OPERATIONAL DEFINITIONS

Effectiveness

Refers to the extent to which the structured teaching progrmme on post operative self care will achieve the desired results which is measured by post test questionnaire.

Pre operative

Refers to the period before caesarean section.

Post operative

Refers to the period 24 hours after caesarean section up to 3 days.

Structured teaching

Refers to the information booklet provided to the primi gravida mothers posted for elective caesarean section about post operative self care.

Knowledge

Refers to the correct response to knowledge questions as measured by structured questionnaire.

Elective caesarean section

Refers to a planned operative procedure, delivery of the baby has been made during the pregnancy and before the onset of labour.

Self care

It refers to the activities; the mother is able to perform independently after cesarean section

Primi Mothers

In this study primi mothers refers to the first time pregnant women undergoing elective caesarean section.

1.5. ASSUMPTIONS:

1. Primi mothers have inadequate knowledge about post operative self care after caesarean section.
2. Primi mothers will not practice post-operative self-care properly after caesarean section.
3. Importing the knowledge of post operative self care in the antenatal period will improve the maternal and fetal wellbeing.

1.6. HYPOTHESIS.

H1 - There is a significant difference between the pre test and post test level of knowledge on post operative self care among primi mothers undergoing elective caesarean section.

H2 - There is a significant association between the post test levels of knowledge with selected demographic variables.

1.7. DELIMITATIONS.

- The study is delimited to the Institute of Obstetrics and Gynaecology, and Hospital for Women and Children, Egmore, Chennai -8.
- The study is delimited to primi mothers who are undergoing elective caesarean section.
- The sample size is limited to 60 patients.
- The mothers who are willing to participate in the study.

CHAPTER- II

REVIEW OF LITERATURE

Search for review of literature to familiarize with knowledge base. It helps to incorporate with up to date knowledge about the topic and to decide criteria for including or excluding subject and problems related to study. It helps to organize and presents a review of selected literature relevant to present study.

It consists of two sections

2.1 Deals with literature review related to the study

2.2. Deals with conceptual frame work

2.1.1: Literature related to elective cesarean section

2.1.2: Literature related to breast feeding and breast care

2.1.3: Literature related to newborn care

2.1.4: Literature related to perineal care

2.1.5: Literature related to postnatal exercise

2.1.6: Literature related to temporary family planning

2.1.1: Literature related to elective cesarean section

Herstad *L., et al* (2016), A study was conducted to examine the association between maternal age and adverse outcomes by delivery modes, both planned and performed. 583 women, aged ≥ 35 years, low-risk primiparas with singleton, cephalic labors at ≥ 37 weeks were included. Outcomes studied were obstetric blood loss, maternal transfer to intensive care units, 5-min Apgar score, and neonatal complications. Moderate blood loss was three times more likely in elective and emergency cesarean section than in unassisted vaginal delivery, and twice as likely in operative vaginal delivery. Low Apgar score and neonatal complications occurred two to three times more often in emergency operative deliveries. In elective cesarean section and planned vaginal delivery, only moderate blood loss, neonatal transfer to NICU and neonatal infections differed significantly.[9]

Mylonas I and Friese K, (2015), A study was conducted on Indications for Elective Cesarean Section. The rate of cesarean section increased due to changed risk profiles both for expectant mothers and for their yet unborn children. In 1991, 15.3% of all newborn babies in Germany were delivered by cesarean section; by 2012, 31.7%. In that a medical indication was present in less than 10% of all cases. Scientific advances, social and cultural changes, and medico legal considerations are the main reasons for the increased acceptability of cesarean sections. Cesarean section is associated with increased risks to both mother and child. It should only be performed when it is clearly advantageous.[10]

Khaskheli MN., et al (2014), A cohort study was done to determine the effect on subsequent mode of labour in case of previous elective caesarean for breech presentation in primiparous women, Jamshoro. Out of the total, 131 (16.92%) women had previous elective caesarean section due to breech presentation while 643 (83.07%) women had previous elective caesarean section with cephalic presentation. Overall repeat caesarean section rate was 92 (70.22%) in women with previous breech presentation (n=131) in comparison with 475 (73.87%) women with previous cephalic presentation n=643 (RR=1.04, p=0.32). The vaginal birth rate after elective caesarean section due to breech presentation was 39 (29.77%) in comparison with 168 (26.12%) cases with previous cephalic presentation (RR=0.98, p=0.83).[11]

Suwal A., et al (2013), A prospective study was done to compare the maternal and fetal outcome in elective and emergency cesarean section in Nepal Medical College. The incidence of cesarean section was 254 (22.30%), 167 (65.7%) were emergency cesarean section, 87 (34.3%) were elective cesarean section for. The usual indications of emergency cesarean section were fetal distress, previous cesarean section in labour, non-progress of labour and prolonged second stage of labour. The usual indications of elective cesarean section were previous cesarean section, breech, cephalopelvic disproportion and cesarean section on demand. There was found to be no significant difference in age, period of gestation, blood loss and blood transfusion in emergency vs. elective cesarean section. There was significant difference seen in the length of hospital stay, fever, urinary tract infection, wound

infection and low APGAR in five minutes indicating that these were more common in emergency cesarean section. The overall complication rate is higher in emergency cesarean section than in elective cesarean section.[12]

Ghazi A., et al (2012), A cross-sectional comparative study was conducted to compare maternal morbidity and determine its cause in elective and emergency caesarean section in Civil Hospital Karachi at Obs/Gyn Unit III. Patients undergoing emergency C/S were placed in group A, and those delivered by elective C/S were included in group B. Study variables were general and obstetric parameters and complications observed intra-operatively. Any postoperative complications were recorded from recovery room till patient was discharged from the ward. There were 50 patients in each group. In group A, 11 (22%) were booked and 33 (66%) were referred cases. In group B, 48 (96%) were booked. The mean age in both groups was 28 years. In both groups, multigravida compared to primi gravida were 78% vs 22% in group A, and 92% vs 8% in group B. Indication for C/S was previous C/S in 10 (20%) patients in group A, and 39 (78%) patients in group B, placenta previa, chorio amionitis, obstructed labour (6, 12% each); pregnancy induced hypertension and eclampsia in 5 (10%) cases in group A only. Intra-operative complications in group A were 48 (96%) vs 15 (30%) in group B ($p = 0.000$). Postoperative morbidity in group A was 50 (100%) and 26 (52%) in group B ($p = 0.000$). Intra-operative complication was haemorrhage in 46 (92%) cases in group A and 11 (22%) in group B. Anaesthetic complications were 40 (80%); prolonged intubation 25 (50%), aspiration of gastric contents 8 (16%), and difficult intubation 7 (14%) in group A. Ten (20%) cases had anaesthetic complications in group B. Commonest postoperative complication in both groups was anaemia in 41 (82%) and 11 (22%) cases respectively. Maternal morbidity is significantly higher in emergency C/S.[13]

Onwere C., et al (2011), A retrospective cohort study was conducted to assess the impact of placenta praevia on maternal complications after elective caesarean section (CS) of women who had an elective CS for a singleton at term in the English National Health Service between 1 April 2000 and 28 February 2009 using routine data from the Hospital Episode Statistics database. Among 131,731 women having

an elective CS for a singleton, 4,332 (3.3%) women had placenta praevia. Placenta praevia increased the risk of postpartum haemorrhage from 9.7% to 17.5% (adjusted odds ratio (OR) 1.91; 95% CI: 1.74 to 2.09), the risk of blood transfusion from 1.4% to 6.4% (OR 4.39; 3.76 to 5.12), and the risk of hysterectomy from 0.03% to 1% (OR 39.70; 22.42 to 70.30). Previous studies have estimated the rate of hysterectomy among women with placenta praevia to be 5%. Placenta praevia remains a risk factor for various maternal complications, although the increased risk of hysterectomy is lower than previously reported.[14]

Suzuki S., et al (2010) reviewed the obstetric records of 292 twin deliveries with vertex presentation of the first twin after 37 weeks' gestation at our hospital from 2000 through 2008. The study period was divided into 3 parts as follows: period 1: 2000 through 2002 (n=76); period 2: 2003 through 2005 (n=104); and period 3: 2006 through 2008 (n=112). We compared the rate of elective cesarean delivery due to maternal request and the incidence of transient tachypnea of the newborn (TTN). There has been a significant increase in rate of elective cesarean delivery period 1: 18%; period 2: 25%; period 3: 48% over the past several years. This increase was observed to be due to an increase in maternal requests for elective cesarean delivery. However, there were no significant differences in the incidence of TTN in the 3 periods [period 1: 7.2%; period 2: 6.7%; period 3: 8.0%]. The recent increase in the rate of cesarean delivery did not cause the increase in the incidence of neonatal respiratory disorders in twin pregnancies.[15]

2.1.2: ***Literature related to breast feeding and breast problem***

Zanardo V., et al (2013), A Cohort study was done to investigate the effects of elective primary and elective repeat caesarean deliveries on lactation at hospital discharge, in Four Italian teaching hospitals - Padua, Brescia, L'Aquila and Udine. Deliveries were classified as vaginal, elective caesarean (primary and repeat) or emergency caesarean. A total of 2296 (24.7%) infants born by caesarean section (CS), 816 of which (35.5%) classified as primary elective CS and 796 (34.7%) as repeat elective CS, were studied. Moreover, 30.2% of the elective CS deliveries took place before 39 weeks. At discharge, 6.9% of the vaginal delivery mothers, 8.3% of the

emergency CS mothers, 18.6% of the elective CS mothers, 23.3% of the primary CS mothers and 13.9% of the repeat CS mothers were using infant formula exclusively. Multivariate analysis (OR; 95% CI) identified primary elective delivery (3.74; 3.0 to 4.60), lower gestational age (1.16; 1.10 to 1.23), and place L'Aquila versus Udine (1.42; 1.01 to 2.09) and of Brescia versus Udine hospitals (6.16; 4.53 to 8.37) as independent predictors of formula feeding at discharge. These findings provide new information about the risks of breastfeeding failure connected to elective CS delivery, particularly if primary and scheduled before 39 weeks of gestation.16

***Vijayalakshmi P., et al* (2015),** A cross sectional descriptive study was carried out among randomly selected postnatal mothers at Pediatric outpatient department at a tertiary care center to examine the knowledge and attitude towards breast feeding and infant feeding practices among Indian postnatal mothers. Data was collected through face-to-face interview using a structured questionnaire. findings revealed that a majority (88.5%) of the mothers were breast feeders. However, merely 27% of the mothers were exclusive breast feeders and only 36.9% initiated breast feeding within an hour. While mothers have good knowledge on breast feeding (12.05±1.74, M±SD), the average score of the Iowa Infant Feeding Scale (IIFAS) (58.77±4.74, M ±SD) indicate neutral attitudes toward breastfeeding. Mothers those who were currently breast feeding (58.83 ± 4.74) had more positive attitudes than non-breastfeed mothers (45.21±5.22). Findings also show that the level of exclusive breast-feeding was low. Thus, it is important to provide prenatal education to mothers and fathers on breast-feeding.[17]

Himani, BaljitKaur and Praveen Kumar (2011) conducted a study to assess the effect of initiation of breast feeding within one hour of the delivery on maternal-infant bonding. Two hundred and eighteen mother- infant dyads were enrolled for the study and considered for analysis. Each group (control and experimental) comprised of one hundred and nine mother-infant dyads. Mothers who initiated breast feeding after one hour of the delivery were considered in the control group and the mothers in the experimental group initiated breastfeeding within one hour of the delivery. Value of t at 24 hrs was -7.428 and at 48 hrs was -8.894. Significant difference p= 0.000 <

0.5 was found between the maternal infant bonding scores of control and experimental group at 24 as well as 48 hours of the delivery. At 24 hours of the delivery, mean ± S.D of score was found 73.6 ± 9.0 in the control group while the score was 81.1 ± 5.3 in the experimental group and at 48 hours it was 74.5 ± 8.9 in control group and 83.3 ± 5.3 in the experimental group. The result revealed that initiation of breast feeding within one hour of delivery improves maternal- infant bonding. So, it is recommended that breast feeding should be initiated within one hours of delivery.[18]

Ahn S., et al (2011) conducted a non-synchronized nonequivalent control group pretest-posttest study to assess the effects of breast massage on breast pain, breast-milk sodium, and newborn suckling in early postpartum mothers. Sixty postpartum mothers who were admitted to a postpartum care center and had problems with breastfeeding were recruited.[44] were assigned to the intervention group and received two 30-minute breast massages within 10 days of postpartum period. Others were assigned control group and received only routine care. Breast pain was measured using a numeric pain scale and number of times newborns suckled was observed throughout breastfeeding. Breast milk was self-collected to evaluate breast-milk sodium. The results show that the Mean age of postpartum mothers was 30 years old. Compared to the control group, women in the intervention group reported significant decreases in breast pain ($p<.001$), increases in number of times newborns suckled after the first and second massage ($p<.001$), and a decrease in breast-milk sodium after the first massage ($p=.034$).So finally Breast massage may have effects on relieving breast pain, decreasing breast-milk sodium, and improving newborn suckling.[19]

Brown Arnott B (2014) conducted a study assess the effectiveness of Breastfeeding duration and early parenting behaviour: the importance of an infant-led, responsive style. The aim of this study was to explore the association between early parenting behaviours and breastfeeding duration. Five hundred and eight mothers with an infant aged 0-12 months completed a questionnaire examining breastfeeding duration, attitudes and behaviours surrounding early parenting (e.g. anxiety, use of routine, involvement, nurturance and discipline). Participants were attendees at baby groups or participants of online parenting forums based in the UK. The study results

showed that Formula use at birth or short breastfeeding duration were significantly associated with low levels of nurturance, high levels of reported anxiety and increased maternal use of Parent-led routines. Conversely an infant-led approach characterized by responding to and following infant cues was associated with longer breastfeeding duration. Maternal desire to follow a structured parenting approach which purports use of Parent-led routines and early demands for infant independence may have a negative impact upon breastfeeding duration. Increased maternal anxiety may further influence this relationship. The findings have important implications for Health Professionals supporting new mothers during pregnancy and the postpartum period.[20]

***Awi DD., et al (2006*)**, A study was conducted to determine the barriers to timely initiation of breast feeding among mothers in WHO hospital (500 consecutive health mother-infant both vaginally and by cesarean section) were selected. Information was obtained using a structured questionnaire. Approximately 34% of the vaginal delivery mother initiated breast feeding early while no mother with cesarean section had had early initiation of breast feeding. The mean time of breast feeding initiation was 3.35-/+2.6 hrs in mother who had vaginal delivery, 6.50+/-3.4 hrs and 5.9+/-1.9 hrs in those who had cesarean section with general or spinal anesthesia respectively. They concluded that there was a low pre valence of early initiation of breast feeding in mothers delivered at the university of Port Harcourt Hospital. This low prevalence was due to practices interfere with the time of breast feeding initiation.[21]

Ahluwalia IB., et al (2005), A study was conducted to examine the breastfeeding behaviors, period of vulnerability for breastfeeding cessation, reasons for breast feeding cessation and the association between pre delivery intentions and breastfeeding behaviors. Using a two years (2000 & 2001) of data from the pregnancy Risk Assessment and Monitoring system, assessment of percentage of women who began breastfeeding, continued for less than one week, continued for 1-4 weeks and continued for more than 4 weeks. Results revealed that 32% of women did not initiate breastfeeding, 4% started but stopped within the first week, 13% stopped within the first month and 51% continued for more than 4 weeks. Reasons for cessation included

sore nipples, inadequate milk supply. Study concluded that there is a need to provide extensive difficulties in breastfeeding.[22]

Scott JA., et al (2007), A longitudinal study of 420 breastfeeding women was undertaken in Glasgow to find incidence of mastitis in the first six months postpartum. Participants were recruited and completed a baseline questionnaire before discharge from hospital. Cases of mastitis were reported either directly to the researches or were detected during regular follow-up telephone interviews at weeks 3, 8, 18 and 26. Results show that 74 women (18%) experienced at least one episode of mastitis. More than one half of initial episodes (53%) occurred within the first four weeks postpartum. They concluded that **approximately** one in six women is likely to experience one or more episodes of mastitis while breastfeeding. A small but clinically important proportion of women continue to receive inappropriate management advice from health professionals which, if followed, could lead them to unnecessary deprive their infants prematurely of the known nutritional and immunological benefits of breast milk.[23]

***Goyal RC., et al (2011*)**, An observational, descriptive, cross-sectional study was done at AL Jamahiriya and AL Fatech hospital in Benghazi, Libiya from November 2009-February 2010. The objective of the study was to assess the correct position, attachment and effective sucking in the breastfeeding of infants. One hundred ninety-two-mother-neonate units were observed for mother's and baby's position, attachment and effective sucking using WHO B-R-E-A-S-T Feed observation form. Grading of positioning, attachment and sucking was done according to the score of various characteristics. Results show that there was poorer positioning among primipara and also poor attachment was also evident. Poor attachment was related to cracked nipples and mastitis. Study concluded that young primipara mothers were more in need of support and guidance for appropriate breastfeeding techniques.[24]

2.1.3: Literature related to newborn care

Essa RM., et al (2015) conducted a non-randomized controlled clinical trial done at a labor and delivery unit of National Medical Institution in Damanhour, Albehera Governorate, Egypt. A purposive sample of 100 laboring women was

recruited. Study group (50) who considered skin–to-skin contact (SSC) and a control group (50) who received routine hospital care. The aim of this study was to determine the effect of early maternal /newborn skin-to-skin contact after birth on the duration of third stage of labor and initiation of breastfeeding. The results revealed that success in first breastfeeding was higher among study group compared to control group. There are statistically significant differences between the study and control groups in third stage of labor duration, complete placental separation, and immediate contraction of the uterus, position of uterus, absence of any abnormal signs such as uterine atony or excessive blood loss. The mean duration of the third stage of labor in the study group was significantly shorter (2.8 ± 0.857 minutes) than among those in the control group (11.22 ± 3.334 minutes) ($p < .01$). The study concluded that mothers who practice early maternal/newborn SSC immediately after birth experience shorter duration of the third stage of labor and early successful initiation of breastfeeding.[25]

Askelsdottir B., et al (1999), A retrospective case-control study was done in a labour ward unit in Stockholm, Sweden,96 women with single, uncomplicated pregnancies and births, and their healthy newborns were participated. Early discharge at 12-24 hours post partum with 2-3 home visits during the first week after birth. The intervention group consisted of women who had a normal vaginal birth (n=45). This group was compared with healthy controls who received standard postnatal care at the hospital (n=51). Mother's sense of security was measured using the Parents' Postnatal Sense of Security Scale. Contact between mother, child and father, and emotions towards breast feeding were measured using the Alliance Scale, and breast-feeding rates at one and three months post partum were recorded.women in the intervention group reported a greater sense of security in the first postnatal week but had more negative emotions towards breast feeding compared with the control group. At three months post partum, 74% of the newborns in the intervention group were fully breast fed versus 93% in the control group (p=0.021). Contact between the mother, newborn and partner did not differ between the groups. Early discharge with home care is a feasible option for healthy women and newborns.[26]

Turner N., et al (1999), A prospective prevalence survey of 504 mothers of newborn babies recruited from birthing centres in urban Auckland over the period November 1997 to February 1998. A postal questionnaire was sent at ten weeks postnatal, covering issues concerning the six-week check, six-week immunisation and breast feeding. Four hundred and four completed questionnaires were obtained (82%); 98% of respondents had obtained a six-week check and 90% a six-week immunisation for their infant. Infants who received their six-week check from a general practitioner were more likely to be immunised. Younger mothers (15-19 years) and older mothers (35 years plus) were less likely to have immunised children. Of reasons given for not immunising, 43% were concerns over immaturity of the baby and 27% because the child was not well. At birth, 88% of mothers were fully breast feeding and 62% at six-weeks postnatal. Of the reasons given for stopping feeding, 41% stated insufficient milk or poor weight gain and 15% stated failure to establish feeding.[27]

Shrestha T., et al (2013), A descriptive study was done to assess the Knowledge, attitudes, and breast feeding practices of postnatal mothers among 100 purposively selected post natal mothers admitted in Teaching Hospital. Semi-structured interview questionnaire and observation checklist was used to collect the data. Respondents' mean knowledge was on keeping newborn warm 44.2, on newborn care 47.2, on immunization 67.33, on danger signs 35.63. All (100%) respondents had have knowledge and practice to feed colostrums and exclusive breast feeding, 70 (70%) knew about early initiation of breastfeeding. Mean knowledge and practice of respondents was on measures to keep warm 8.5 and 17. Although 60 (60%) had knowledge to wash hands before breastfeeding, and after diaper care, only 10 (10%) followed it in practice. Mean practice of successful breast feeding was 37.5, 12 (60%) applied nothing kept cord dry. Postnatal mothers have adequate knowledge on areas like early, exclusive breast feeding, colostrums feeding, they have not much satisfactory knowledge in areas like hand washing, danger signs etc.[28]

Bystrova K et al., (2009) conducted a study to assess early contact versus separation: effects on mother-infant interaction one year later the aim of this study was to evaluate and compare possible long-term effects on mother-infant interaction

of practices used in the delivery and maternity wards, including practices relating to mother-infant closeness versus separation. A total of 176 mother-infant pairs were randomized into four experimental groups: Group I infants were placed skin-to-skin with their mothers after birth, and had rooming-in while in the maternity ward. Group II infants were dressed and placed in their mothers' arms after birth, and roomed-in with their mothers in the maternity ward. Group III infants were kept in the nursery both after birth and while their mothers were in the maternity ward. Group IV infants were kept in the nursery after birth, but roomed-in with their mothers in the maternity ward. Episodes of early suckling in the delivery ward were noted. The mother-infant interaction was videotaped according to the Parent-Child Early Relational Assessment (PCERA) 1 year after birth. The study results shows that the practice of skin-to-skin contact, early suckling, or both during the first 2 hours after birth when compared with separation between the mothers and their infants positively affected the PCERA variables maternal sensitivity, infant's self-regulation, and dyadic mutuality and reciprocity at 1 year after birth. These findings support the presence of a period after birth (the early "sensitive period") during which close contact between mother and infant may induce long-term positive effect on mother-infant interaction. We concluded that Skin-to-skin contact, for 25 to 120 minutes after birth, early suckling, or both positively influenced mother-infant interaction 1 year later when compared with routines involving separation of mother and infant.[29]

Srivastava S et al., (2014) done a Randomized control trial study on Effect of very early skin to skin contact on success at breastfeeding and preventing early hypothermia in neonates. Conducted over 2 years' period in a tertiary care hospital. Healthy babies delivered normally were included. Very early SSC between mothers and their newborns was initiated in the study group. We studied effective suckling (using modified infant breastfeeding assessment tool [IBFAT]), breastfeeding status at 6 weeks, maternal satisfaction, thermal regulation, baby's weight and morbidity. T-test, Pearson Chi-square test and non-parametric Mann-Whitney test were used through relevant Windows SPSS software version 16.0.We observed that SSC contributed to better suckling competence as measured by IBFAT score ($P < 0.0001$). More babies in the SSC group were exclusively breastfed at first follow-up visit ($P =$

0.002) and at 6 weeks (P < 0.0001). SSC led to higher maternal satisfaction rates, better temperature gain in immediate post-partum period, lesser weight loss was at discharge and at first follow-up (all P < 0.0001) and lesser morbidity than the study group (P = 0.006).we concluded that Very early SSC is an effective intervention that improves baby's suckling competence, maternal satisfaction, breastfeeding rates and temperature control and weight patterns.[30]

Visscher M., et al (2009). A study was conducted to test the hypothesis that baby diaper wipes with emollient cleansers and a soft cloth would minimize skin compromise relative to cloth and water. In 130 NICU infants (gestational age 23-41 weeks, at enrollment 30-51 weeks), measurements of skin condition, i.e., skin erythema, skin rash, transepidermal water loss (TEWL) and surface acidity (pH), within the diaper and at diaper and chest control sites were determined daily for 5-14 days using standardized methods. Treatments were randomly assigned based on gestational age and starting skin irritation score: wipe A, wipe B, and the current cloth and water NICU standard of care. Perineal erythema and TEWL were significantly lower for wipes A and B than cloth and water beginning at day 5 for erythema (scores of 1.11 +/- 0.05, 1.2 +/- 0.05, and 1.4 +/- 0.06, respectively) and day 7 for TEWL (28.2 +/- 1.6, 28.8 +/- 1.6, and 35.2 +/- 1.6 g/m(2)/h, respectively). Wipe B produced a significantly lower skin pH (day 5, 5.47 +/- 0.03) than wipe A (5.71 +/- 0.03) and cloth and water (5.67 +/- 0.04). The starting skin condition, stool total, age and time on current standard impacted the outcomes. Both wipes are appropriate for use on medically stable NICU patients, including both full and preterm infants, and provide more normalized skin condition and barrier function versus the cloth and water standard. Wipe B may facilitate acid mantle development and assist in colonization, infection control and barrier repair. Neonatal skin continues to change for up to 8 weeks postnatally, presumably as it adapts to the dry extra-uterine environment.[31]

2.1.4: Literature related to perineal care

Hossain MA., et al (2008). A study was conducted at the tertiary referral Orthopaedic Unit of St. Georges Hospital, it was noted that there was an unacceptably high number of soiled perinea in patients transferred from Base Hospitals. This not

only exposed the patients to increased infection but was also undignified and unacceptable for them. We decided to audit the problem with a view to finding out why this was happening and to improve the situation. A 2-year study was carried out over three distinct phases (phase 1: February-June 2004, phase 2: July-November 2004, phase 3: February-November 2005). Observations of soiling were recorded in a questionnaire by the surgeon prior to surgery. Key system and clinical guidelines were implemented during the second phase, and the audit process was repeated. The percentage of clean perinea in phase 1 was 32%, phase 2 68% and phase 3 99.5% indicating a clear improvement in the overall system.[32]

Cornejo JP., et al (2003). A study was conducted on Vulvar amebiasis from Report of a case and review of the literature. Genital amebiasis by Entamoeba histolytica is rare, even in Mexico where the disease is endemic. We report a case of genital amebiasis in a female patient with a recto-perineal fistula and two-week history of a profuse vaginal discharge, a painful and friable vulvar ulcer and induration in gluteal and inner side of thighs. The PAP smear and the biopsy showed trophozoites, no malignant cells were observed. The findings were compatible with genital amebiasis. The serology test for E. histolytica was positive (> 1: 512). The patient was treated with metronidazol 750 mg tid for 3 weeks. Complete resolution was achieved. The long term fistula, the low socioeconomic status, the poor hygiene and diabetes mellitus of a recent onset were probably the risk factors associated to this infection.[33]

2.1.5: Literature related to postnatal exercise

***Pei-Ching Tseng., et al (2015*)**, A systematic review of randomised controlled trials was done to assess the effectiveness of exercise programs on Lumbo Pelvic Pain among postnatal women. A comprehensive search of following databases: PubMed, PEDro, Embase, Cinahl, Medline, SPORTDiscus, Cochrane Pregnancy and Childbirth Group's Trials Register, and electronic libraries of authors' Institutions was done. Selected articles were assessed using the PEDro Scale for methodological quality. Four randomised controlled trials were included, involving 251 postnatal women. The trials included physical exercise programs with varying components, differing modes

of delivery, follow up times and outcome measures. Intervention in one trial, involving physical therapy with specific stabilising exercises, proved to be effective in reducing LPP intensity. An improvement in gluteal pain on the right side was reported in another trial and a significant difference in pain frequency in another. There is some evidence to indicate the effectiveness of exercise for relieving LPP.[34]

Benjamin DR., et al (2013). A randomised controlled trial was conducted to determine if non-surgical interventions (such as exercise) prevent or reduce DRAM at Physiotherapy Department, Angliss Hospital, Australia. Data sources EMBASE, Medline, CINAHL, PUBMED, AMED and PEDro were searched. Study selection/eligibility Studies of all designs that included any non-surgical interventions to manage DRAM during the ante- and postnatal periods were included. Eight studies to talling 336 women during the ante- and/or postnatal period were included.. All interventions included some form of exercise, mainly targeted abdominal/core strengthening. The available evidence showed that exercise during the antenatal period reduced the presence of DRAM by 35% (RR 0.65, 95% CI 0.46 to 0.92), and suggested that DRAM width may be reduced by exercising during the ante- and postnatal periods.[35]

Daley J., et al (2015), A pragmatic randomized controlled trial was done to evaluate the effectiveness of a facilitated exercise intervention as a treatment for postnatal depression. The intervention involved two face-to-face consultations and two telephone support calls with a physical activity facilitator over 6 months to support participants to engage in regular exercise. The primary outcome was symptoms of depression using the Edinburgh Postnatal Depression Scale (EPDS) at 6 months post-randomization. Secondary outcomes included EPDS score as a binary variable (recovered and improved) at 6 and 12 months post-randomization. A total of 146 women were potentially eligible and 94 were randomized. Of these, 34% reported thoughts of self-harming at baseline. After adjusting for baseline EPDS, analyses revealed a −2.04 mean difference in EPDS score, favouring the exercise group [95% confidence interval (CI) −4.11 to 0.03, p = 0.05]. When also adjusting for pre-specified demographic variables the effect was larger and statistically significant

(mean difference = −2.26, 95% CI −4.36 to −0.16, p = 0.03). Based on EPDS score a larger proportion of the intervention group was recovered (46.5% v. 23.8%, p = 0.03) compared with usual care at 6 months follow-up. An exercise intervention an effective treatment for women with postnatal depression, including those with thoughts of self-harming.[36]

Mohammadi F., et al (2014). A randomized controlled trial was done to determine the effectiveness of home-based low-intensity stretching and breathing exercises on the reduction of 1 and 2 month post-partum depression (primary outcome) and fatigue (secondary outcome) scores. In this randomized controlled trial, 127 women at 26–32 weeks' gestation with Edinburgh score less than 15, who attended 14 selected health centres in Tabriz, Iran, were randomly allocated into one of the following three groups: no intervention group, group receiving training for exercise during pregnancy, and group receiving training for exercise during pregnancy and post-partum period until 2 months after delivery. Depression and fatigue scores were measured using the Edinburgh Postnatal Depression Scale and Fatigue Identification Form, respectively, at baseline, 1 month and 2 months after delivery. The data were analysed with SPSS-ver. 13.0 (SPSS Inc, Chicago, IL, USA) using chi-square, Fisher's exact and Kruskal– Wallis tests. Mean rank of the difference scores of depression and fatigue were not significantly different among the groups, both at 1 and 2 months post-partum (P > 0.05). Therefore, this study did not provide evidence to show that training women to do the home-based exercises during pregnancy or and post-partum period have a preventive effect on post-partum depression and fatigue.[37]

Li HT., et al (2013). A study was conducted to determine the association of cesarean section with offspring obesity. Cohort or case-control studies that reported the association of cesarean section with childhood (3-8 years), adolescence (9-18 years) and/or adult (>19 years) overweight/obesity were eligible. Statistical heterogeneity was assessed with I (2) statistics; the values of 25%, 50% and 75% were considered to indicate low, medium and high heterogeneity, respectively. We conducted a subgroup analysis to identify the sources of heterogeneity according to study quality defined on the basis of the Newcastle-Ottawa Scale. In total, two case-

controls and seven cohort studies were identified for the literature review and 15 separate risk estimates were included in the meta-analysis. The overall pooled odds ratio (OR) of overweight/obesity for offspring delivered by cesarean section compared with those born vaginally was 1.33 (95% confidence interval (CI) 1.19, 1.48; I(2)=63%); the OR was 1.32 (1.15, 1.51) for children, 1.24 (1.00, 1.54) for adolescents and 1.50 (1.02, 2.20) for adults. In subgroup analysis, the overall pooled OR was 1.18 (1.09, 1.27; I(2)=29%) for high-quality studies and 1.78 (1.43, 2.22; I(2)=24%) for medium-quality (P for interaction=0.0005); no low-quality studies were identified. Our results indicated that cesarean section was moderately associated with offspring overweight and obesity.[38]

Winnie W., et al (2008) conducted a prospective cohort study of194 patients randomly selected after Cesarean delivery. Venous Thromboembolism is the leading cause of maternal mortality in the U.S. Cesarean delivery increases the risk of Venous thromboembolism Participants underwent lower extremity compression ultrasound prior to hospital discharge. Information was obtained through interviews and examinations. Within the group of 194 participants, the rate of DVT was 0.5% the mean age was 29.9 yr. Ten percent were emergency Cesarean delivery and 2% of participants received general anesthesia. Fifteen percent were on bed rest prior to delivery and 14%smoked during pregnancy. Findings suggest a low rate of DVT post CD of 5per 1000.after anti coagulation therapy.[39]

2.1.6: Literature related to temporary family planning

Bhattarai D and Panta OB (2013) A cross sectional study was done to find the contraceptive prevalence, knowledge, attitude and practice of contraceptive use, conducted at four health facilities at Khotang district during reproductive health camp in January 2011 by interviewing using a predesigned questionnaire. The mean age of 112 women who participated in the study was 25.3±6.1 and most were predominantly Mongolians and multipara. The knowledge of family planning was wide spread with clients listing 5±1 methods on average. Depopovera was the most commonly listed. Total 87 (77.7%) women had positive attitude towards family planning were positive in using contraceptives if needed. Other 22 (19.6%) were indecisive and wanted to

consult husband and a very few did not want any contraception. Implant was preferred by most followed by Depo Provera. Seventy eight (69.6%) had ever used modern temporary method contraceptive devices and 41 (31.6%) were currently using them. Depopovera was the most common method ever used or currently in use. Knowledge of contraceptive is high in Nepal even in remote area.[40]

Gupta S., et al (2012) A cross sectional descriptive study was carried out from October 2011 till December 2011 at Lamjung district hospital of Nepal to assess the family planning practice and methods among the married women of reproductive age attending female clinic. One hundred randomly selected married women of 15-49 years, who had at least one child were the subjects of the study. A structured questionnaire on knowledge, practice and methods of use of contraception was composed and filled up. The results were encouraging with 94 (94%) of participants having knowledge about contraception. Among them 64 (68%) were using modern contraception methods. The study showed that 32 (32% of the married women belonged to 20-24 years of age group. Injectables hormonal contraceptives were most commonly practiced by 34 (54%) women. Among not using any contraceptives, 18 (60%) of them said their husband being abroad. Family planning knowledge and practice among the rural women utilizing the service was appreciable. Temporary method of contraception was most commonly practiced.[41]

CONCEPTUAL FRAME WORK

A Conceptual framework is a theoretical approach to the study of the problem that is scientifically based and emphasizes the selection, arrangement, and classification of its concept. The conceptual framework states functional relationships between events and is not limited to statistical relationships.

The study has intended the effectiveness of structured teaching programme in terms of increasing knowledge on selected post-operative self care for primi mothers undergoing elective caesarean section in Institute of Obstetrics and Gynaecology, and Govt. hospital for Women and Children, Egmore, Chennai-3."

The present study is based on general system theory which was introduced by Ludwig Von Bertalanffy (1968) with input, throughput, output, and feedback.

According to the system's theory, a system is a group of elements that interact with one another in order to achieve the goal. An individual is a system because he/she receives input from the environment. This input when processed provides an output. This system is cyclical in nature and continues to be so, as long as the input, throughput, output and feedback keep interacting. If there are changes in any of the parts, there will be changes in all parts. Feedback from within the systems or from the environment provides information, which helps the system to determine whether it meets its goal.

In the present study these concepts can be explained as follows:

Input

The input consists of information material or energy that enters the system. For a system to work well the input should concentrate in achieving the purpose of the system. The primi mothers, admitted in antenatal ward undergoing elective caesarean section in Institute of Obstetrics and Gynaecology, and Govt. hospital for Women and Children, Egmore, Chennai is a system and has inputs within the systems itself and acquired from the environment.

In this study, the input process includes

- Demographic variables like age, religion, educational status, and occupational status, monthly income, type of family and living place.
- Assessment of knowledge on selected post-operative self-care for primi mothers undergoing elective caesarean section in Institute of Obstetrics and Gynaecology, and Govt. hospital for Women and Children, Egmore, using semi structured questionnaire.

Throughput / process:

It refers to the action needed to accomplish the derived task to achieve the desired output, i.e. effectiveness of structured teaching programme on knowledge of selected post-operative self-care for primi mothers undergoing elective caesarean section in Institute of Obstetrics and Gynaecology, and Govt. hospital for Women and Children, Egmore,

- Administration of structured teaching programme.
- Review of STP by flash cards show
- Provided with pamphlet for further references.

Output

An output is the improved responses of the primi gravida mothers undergoing elective cesarean section followed by the implementation of the structured teaching programme. In the present study, output is the gain knowledge score. This system achieved through a comparison between mean pre-test and post-test knowledge score of the samples.

Feedback

It is a process by which information is received at the stage of the system output and its redirection to input. Accordingly, the higher knowledge score obtained by the primi gravida mothers undergoing elective cesarean section indicate that structured teaching programme was effective in increasing the knowledge regarding the post operative self care.

CHAPTE R – III

METHODOLOGY

Research methodology is the systematic procedure by which the investigator starts from Initial identification of the problem to the final conclusion and it involves research approach, setting of the population, selection of sample, description of tool, testing of tool, data collection steps, procedure, and Strategies for gathering, organizing and analyzing the data of the study.

3.1 RESEARCH APPROACH

The investigator selects the **quantitative research approach** for this study.

3.2 STUDY DESIGN

The investigator proposed **Pre- experimental research design** for this Study.

In pre-experimental research design **one group pre-test post-test design** was used.

Table 3.1 Pre-Experimental – One Group Pre-test, Post-test Design

Pre Test	Structured Teaching Programme	Post Test
O1	X	O2

In the present study pre test is administered by means of semi structured questionnaire and then structured teaching programme will be provided to the group. Post test will be conducted by using the same semi structured questionnaire.

O_1= Assess the pre-test level of knowledge on selected post operative self care.

among primi gravida mothers.

X= Structured Teaching Programme on post operative self care.

O_2= Assess the post test level of knowledge among the same group, 7 days after structured teaching programme.

3.3 STUDY SETTING

The study was conducted in antenatal ward in Institute of Obstetrics and Gynaecology and Government Hospital for Women and Children, Chennai. It is a 1075 bedded maternity hospital, tertiary care center and referral center. The hospital is renowned for its excellence in medical experts, nursing care and quality diagnostic services. All facilities are provided for conducting normal, high risk and instrumental deliveries. IOG has departments like neonatal intensive care unit, family planning services, oncology department, endocrinology, human milk bank and genetic department which are rendering comprehensive care for entire Tamil Nadu and for neighboring state like Andhra Pradesh also.

3.4 DURATION OF THE STUDY

The study was conducted for the period of four weeks

3.5 STUDY POPULATION

A target population consists of the total number of people or objects which are meeting the designated set of criteria.

3.5.1: The target population

In this study target population comprises of all primi gravida mothers who are undergoing elective cesarean section within 7 days at Institute of Obstetrics and Gynecology, Egmore, Chennai - 8.

3.5.2: Accessible population

It is the aggregate of cases that conform to designated criteria and also accessible as study subjects for study

Accessible population in this study was all primi gravida mothers who are undergoing elective cesarean section within 7 days, admitted in antenatal ward during the period of data collection at Institute of Obstetrics and Gynaecology, Egmore, Chennai 8.

3.6 SAMPLE

The sample consists of all primi gravida mothers who were admitted in antenatal ward and waiting for elective caesarean section within 7 days with fulfill the inclusion criteria.

3.7 SAMPLE SIZE

The sample size was 60 primi gravida mothers.

3.8 CRITERIA FOR SAMPLE SELECTION

The population was studied and those come under inclusion were selected as the sample and the other elements were excluded from the study.

3.8.1 Inclusion Criteria

- Primi mothers who are undergoing elective caesarean section.
- Primi mothers who are willing to participate in the study.
- Primi mothers who are able to read and understand tamil

3.8.2 Exclusion Criteria

- Primi mothers who are undergoing normal delivery**.**
- Primi mothers who are undergoing repeat LSCS.
- Primi mothers who are not able to read and understand tamil

3.9. SAMPLING TECHNIQUE

The sampling technique used for this study was **Non-probability purposive sampling technique**.

3.10. RESEARCH VARIABLES

The variables mainly included in this study are independent and dependent variable. Dependent variable explains the effect of independent variable

3.10.1. Independent variable

Structured teaching programme regarding selected postoperative self care

3.10.2. Dependent variable

Knowledge of primi gravida mothers regarding selected postoperative self care

3.10.3. Influencing variable

Age, education, occupation, type of family, age at marriage, and living area of antenatal mother is the influencing variable.

3.11. DEVELOPMENT AND DESCRIPTION OF TOOL

3.11.1 Development of tool

A semi structured questionnaire was developed on the basis of objectives of the study. Tool was developed after extensive review of literature from various text books, journals, internet search and discussion and guidance from the experts in the field of Nursing, and Medical experts from the Institute of Obstetrics and Gynaecology. The tool was developed in English and translated into Tamil. Congruency was maintained in translation.

3.11.2. Description of the tool

The tool consisted of two sections:

Part I: Demographic and Obstetrical data

Part II: Semi structured knowledge questionnaire

Part I: It consists of demographic variables of the sample such as age, religion, education, occupation, family monthly income, type of family, area of residence, age at menarche, age at marriage, place of an visit, registration, source of information.

Part II: It consists of 30 multiple choice questions regarding postoperative self care and distributed based on the following aspects:

- Knowledge related to general information on postnatal period
- Knowledge related to Breast care
- Knowledge related to Perineal care
- Knowledge related to Newborn care
- Knowledge related to Postnatal exercise
- Knowledge related to temporary family planning method

Table – 3.2: Blue Print of Structured – Assisted Self-Administered questionnaire

S. No	Categories	Items	Total items	Percentage
1	Knowledge related to general information on postnatal period	1, 2	2	6.66 %
2	Knowledge related to Breast care	3 - 8	6	20 %
3	Knowledge related to Perineal care	9 - 12	4	13.33 %
4	Knowledge related to Newborn care	13 - 22	10	33.33 %
5	Knowledge related to Postnatal exercise	23 - 26	4	13.33 %
6	Knowledge related to temporary family planning method	27 - 30	4	13.33 %
	Total		30	100 %

3.11.3. SCORING PROCEDURE

Table 3.3 Scoring Procedure

Marks	Percentage	Level of Knowledge
Less than 15	Less than 50%	Inadequate
16 - 23	50 – 75%	Moderate
24 – 30	Above 75%	Adequate

Each correct answer carries - One Mark

Each wrong answer carries - Zero Mark

Scoring key for the knowledge

Level of knowledge		**Score**
Adequate	-	76 – 100 %
Moderately	-	50 – 75 %
In adequate	-	0 – 50 %

3.12. CONTENT VALIDITY OF THE TOOL

Validity of the tool was assessed using content validity. Content validity was determined by experts from Nursing experts in the field of Obstetrics and Gynaecology. They suggested certain modifications. The experts' suggestions were incorporated in the tool and the tool was finalized and used for the main study.

3.13. RELIABILITY OF THE TOOL

Reliability of the tool was assessed by using Test-Retest method. There was a significant correlation between test and retest according to Karl Pearson's correlation coefficient the reliability of the tool was 0.80. This score indicates high correlation. Hence the tool was found to be reliable to conduct the main study.

3.14. PROTECTION OF HUMAN SUBJECTS

By submitting the study proposal, the permission was obtained from Institutional Ethics committee. Permission for conducting the study was obtained from the Director of Institute of Obstetrics & Gynaecology and Hospital for Women and Children. All respondents were carefully informed about the purpose of the study and their part during the study and how the privacy will be guarded. Researcher explained the procedure and got written consent from the samples before interviewed. The freedom was given to the clients to leave the study at her without assigning any reason. The study information was kept confidential. Routine care was not disturbed; the investigator followed the ethical guidelines during the data collection procedure.

3.15. PILOT STUDY

The investigator conducted a pilot study with 6 samples in Institute of Obstetrics and Gynaecology, Egmore, in order to check feasibility, relevance and practicability of the study, for a period of one week. According to purposive sampling technique six samples were taken using questionnaire method the effectiveness of structured Teaching Programme on post operative self care among primi mothers undergoing elective caesarean section was assessed. The result of the pilot study showed that there was a positive correlation between the knowledge of mothers of children and the study was found to be feasible.

3.16. DATA COLLECTION PROCEDURE

The study was conducted in Antenatal outpatient department, after obtaining permission from the Director of IOG. Before the data collection, the researcher introduced herself, explained the purpose of the study to the ward staff nurse and primi mothers undergoing elective caesarean section. The confidentiality was assured and consent was obtained from the participants. Three to five participants were selected every day and assured that at any time they can withdraw from the study.

Data collection was done using questionnaire method. In pre test the researcher administered structured questionnaire to each participant to assess the knowledge of primi mothers on selected post-operative self-care. The subjects took 20-30 minutes to answer the questionnaire by interview method. After that a structured teaching programme was conducted on the same day approximately for 30 minutes per subject and pamphlets were provided. After that the researcher clarified many doubts asked by the participants regarding my study and also in general, according to the need of each participant. Then each mother was thanked and instructed to come on seventh day after the pretest. Post test was conducted after 7 days by using the same questionnaire to find out the effectiveness of teaching programme. The data collection process was terminated after thanking the participants for their co-operation. After collecting the posttest questionnaire, now and then, every coding sheet was entered.

The data collection period was 4 weeks. Data was collected for 6 days in a week.

3.17. INTERVENTION PROTOCOL

Place	Antenatal ward, IOG, Chennai.
Intervention Tool	Structured Teaching Programme with pamphlets, flash cards.
Duration	45 minutes.
Time	12 : 00 pm to 12.45 pm
Frequency	One time teaching.

3.18. DATA ENTRY ANALYSIS

- The obtained data were analyzed on the basis of objectives and hypothesis by using the descriptive and inferential statistics.
- Descriptive statistics was used to analyses the frequency, percentage, mean and standard deviation.
- Demographic and Obstetrical variables were analysed in terms of frequency and percentage.
- Knowledge score were given in mean and standard deviation.
- Association between demographic variables and knowledge score were analysed using Pearson chi-square test
- Quantitative knowledge score in pretest and posttest were compared using student's paired t-test.
- Qualitative level of knowledge in pretest and posttest were compared using Stuart-Maxwell test /extended McNemar test
- Association between knowledge gain score with demographic variables are assessed using one way ANOVA F-test and student independent t –test.
- Effectiveness and generalization was given using mean with 95% CI and Percentage with 95%.
- Simple bar diagram, Multiple bar diagram, Pie diagram, Doughnut diagram and Box plot were used to represent the data .
- $P<0.05$ was considered statistically significant. All statistical test are two tailed test.

CHAPTER IV

ANALYSIS AND INTERPRETATION

Analysis is a systematic examination and evaluation of data or information by breaking it in to its component parts to uncover their interrelationships.

Interpretation is the art or process of determining the intended meaning of a written document, such as a constitution, statue, contract, deed, or will.

This chapter deals with the analysis and interpretation of data collected from 60 primi gravida mothers in Institute of Obstetrics and Gynaecology, Egmore, to evaluate the effectiveness of structured teaching programme on selected post operative self care.

The collected data was analyzed by using descriptive and inferential statistics. The collected data were tabulated and presented according to the objectives under the following headings.

OBJECTIVES OF THE STUDY

1. To assess the level of knowledge on post-operative self-care among primi mothers undergoing elective caesarean section.
2. To identify the effectiveness of structured teaching programme on selected post-operative self-care among primi mothers undergoing elective caesarean section.

To find the association between post-test knowledge on post-operative self-care among primi mothers undergoing elective caesarean section with their selected demographic variables

Organization of data

Section-A: Demographic and Obstetric information of primi gravida mothers those who are participated in the study.

Section-B: Assess the pre-test knowledge regarding selected post operative self care in the study group.

Section-C: Assess the post-test knowledge regarding selected post operative self care in the study group.

Section-D: Evaluating the effectiveness of structured teaching programme on knowledge of selected post operative self care in the study group.

Section-E: Association of findings with selected demographic variables.

SECTION-A: DEMOGRAPHIC AND OBSTETRIC INFORMATION OF PRIMI GRAVIDA MOTHERS.

Table 4.1: Demographic and Obstetrical profile in the study group:

Demographic information		No. of Primi gravida mothers	%
Age	18 -23 years	18	30.0%
	24 -27 years	29	48.3%
	> 27 years	13	21.7%
Religion	Hindu	49	81.7%
	Christian	6	10.0%
	Muslim	5	8.3%
Education qualification	Informal education	5	8.3%
	Primary education	11	18.4%
	Middle education	36	60.0%
	Higher secondary	8	13.3%
Occupation status	Self-employee	6	10.0%
	Government	5	8.3%
	Private	10	16.7%
	Housewife	39	65.0%
Monthly income	< Rs.5000	7	11.7%
	Rs.5000-7000	16	26.6%
	Rs.7000-12000	24	40.0%
	> Rs.12000	13	21.7%
Type of family	Nuclear family	36	60.0%
	Joint family	24	40.0%
Living place	Rural	17	28.3%
	Urban	43	71.7%
Age at menarche	11-13 yrs	34	56.7%
	14-16 yrs	24	40.0%
	17-19 yrs	2	3.3%

Age at Marriage	16 -18 years	6	10.0%
	19 -21 years	16	26.7%
	22 -24 years	32	53.3%
	> 24 years	6	10.0%
Place of Antenatal visit	Hospital	31	51.7%
	PHC	29	48.3%
Pregnancy was Registered	Yes	60	100.0%
	No	0	0.0%
Antenatal check up done by	Doctor	34	56.7%
	Staff nurse	21	35.0%
	Village health nurse	5	8.3%
Source of Information	Parents	32	53.3%
	Mass media	11	18.4%
	Health professional	10	16.7%
	No exposure	7	11.6%

Table: 4.1 Shows the demographic and obstetrical information of primi gravida mothers those who were participated in the study.

The data revealed, most of the participants 48.3% (29) were in the age group of 24 – 27 years. Majority of the participants, 81.7%(49) belongs to Hindu religion, 60.0% (36) were studied up to higher secondary level, 65.0% (39) were house wife, 40.0% (24) had income between rupees 7,000-12,000, 60.0%(36) belongs to nuclear family, 71.7% (43) came from urban areas.

In obstetrics variables, most of the participants 56.7% (34) were attained menarche at the Age of 11-13 years. Majority of the participants,53.3% (32) were got married at the age of 22 – 24 years, 51.7% (31) had a antenatal visit in hospitals, 100% participants pregnancy were registered and check-up done by doctors (56.7%), 53.3% got self-care information from their parents

SECTION-B: KNOWLEDGE SCORE OF MOTHER BEFORE AND AFTER STRUCTURED TEACHING PROGRAMME.

Table 4.2: Each domain wise pretest percentage of knowledge on post-operative self-care in the study group

S. No	Domains	No. of questions	Min – Max score	Knowledge score		
				Mean	SD	% of mean score
1	General information on post-natal care	2	0 -2	.70	.56	35.00%
2	Breast care	6	0 - 6	2.32	1.67	38.67%
3	Perineal care	4	0 – 4	1.70	.83	42.50%
4	New born care	9	0 - 9	4.00	2.39	44.44%
5	Post natal exercise	5	0 - 5	2.19	1.04	43.80%
6	Birth control method	4	0 - 4	1.67	.90	41.75%
	TOTAL	30	0 - 30	12.58	3.92	41.93%

Table 4.2 shows each domain wise pre-test percentage of knowledge on post operative self care among primi mothers undergoing elective caesarean section. They were having maximum knowledge in **New born care** (44.44%) and minimum knowledge score in **General information on post-natal care** (35.00%).

TABLE 4.3: OVER ALL PRE-TEST LEVEL OF KNOWLEDGE SCORE

S. No	No. of questions	Min – Max score	knowledge score	
			Mean ± SD score	%
Overall score	30	0 - 30	12.58±3.92	41.93%

Table 4.3 shows, pre-test percentage of knowledge on post operative self care among primi mothers undergoing Elective caesarean section .Overall pretest percentage of knowledge score is 41.93% among primi mothers.

TABLE 4.4: PRETEST LEVEL OF KNOWLEDGE

Level of Knowledge	**No. of *primi mothers***	***%***
Inadequate Knowledge	48	80.0%
Moderate Knowledge	12	20.0%
Adequate Knowledge	0	0.0%
Total	**60**	**100%**

Table No.4.4 shows the primi mothers pretest level of knowledge on selected post operative self car**e** before administration of STP. In general, 80.0% (48) of the primi mothers were having inadequate knowledge and 20.0% (12)of them having moderate knowledge and none of them were having adequate knowledge.

TABLE 4.5: EACH DOMAIN WISE POST TEST PERCENTAGE OF KNOWLEDGE ON POST OPERATIVE SELF CARE IN THE STUDY GROUP

S. No	Domains	No. of questions	Min – Max score	Knowledge score		
				Mean	SD	% of mean score
1	General information on post-natal care	2	0 -2	1.53	.50	76.50%
2	Breast care	6	0 - 6	4.47	1.02	74.50%
3	Perineal care	4	0 - 4	3.25	.75	81.25%
4	New born care	9	0 - 9	7.20	1.57	80.00%
5	Post natal exercise	5	0 - 5	4.02	1.04	80.40%
6	Birth control method	4	0 - 4	3.00	.58	75.00%
	TOTAL	30	0 - 30	23.47	1.84	78.23%

Table 4.5 shows each domain wise post-test percentage of knowledge on post operative self care among primi mothers undergoing elective caesarean section. They were having maximum knowledge in **perineal care** (81.25%) and minimum knowledge score in **Breast care** (74.50%).

TABLE 4.6: OVER ALL POST-TEST KNOWLEDGE SCORE

S. No	No. of questions	Min – Max score	Knowledge score	
			Mean ±SD score	%
Overall Score	30	0 -30	23.47±1.84	78.23%

Table 4.6 shows Overall post-test percentage of knowledge on post operative self care among primi mothers undergoing elective caesarean section. Overall posttest percentage of knowledge score is 78.23% among primi mothers.

TABLE4. 7: POST-TEST LEVEL OF KNOWLEDGE SCORE

Level of knowledge	No. of primi mothers	%
Inadequate knowledge	0	0.0%
Moderate knowledge	13	21.7%
Adequate knowledge	47	78.3%
Total	**60**	**100%**

Table 4.7 shows the primi mothers posttest level of knowledge on post operative self care among primi mothers undergoing Elective caesarean section after administration of structured teaching programme. 78.3% of them were having adequate knowledge and 21.7% of them having moderate knowledge, none of the primi mothers were having inadequate knowledge.

TABLE 4.8: COMPARISON OF PRETEST AND POSTTEST KNOWLEDGE SCORE ON POST OPERATIVE SELF CARE.

S. No	Knowledge on post operative self care	Pre-test		Post-test		Mean Difference	Student's paired t-test
		Mean	SD	Mean	SD		
1	General information on post-natal care	.70	.56	1.53	.50	0.83	t=8.46 P=0.001 *** DF= 59 , Significant
2	Breast care	2.32	1.67	4.47	1.02	2.15	t=7.85 P=0.001 *** DF= 59 , Significant
3	Perineal care	1.70	.83	3.25	.75	1.55	t=11.63 P=0.001 *** DF= 59 , Significant
4	New born care	4.00	2.39	7.20	1.57	3.20	t=13.44 P=0.001 *** DF= 59 , Significant
5	Post natal exercise	2.19	1.04	4.02	1.04	1.83	t=10.22 P=0.001 *** DF= 59 , Significant
6	Birth control method	1.67	.90	3.00	.58	1.33	t=9.96 P=0.001 *** DF= 59 , Significant
	Total	12.58	3.92	23.47	1.84	10.89	t=19.68 P=0.001 *** DF= 59 , Significant

* Significant at P≤0.05

** Highly significant at P≤0.01

*** Very high significant at P≤0.001

Table: 4.8 show the comparison of pretest and posttest mean knowledge score.

Knowledge regarding,

General information on post-natal care, in pretest, mothers are having 0.70 score whereas in posttest they are having 1.53 score. Difference is 0.83. This difference is large and it is statistically significant difference.

Breast care, in pretest, mothers are having 2.32 score whereas in posttest they are having 4.47 score. Difference is 2.15. This difference is large and it is statistically significant difference.

Perineal care, in pretest, mothers are having 1.70 score whereas in posttest they are having 3.25 score. Difference is 1.55. This difference is large and it is statistically significant difference.

New born care, in pretest, mothers are having 4.00 score whereas in posttest they are having 7.20 score. Difference is 3.20. This difference is large and it is statistically significant difference.

Post natal exercise, in pretest, mothers are having 2.19 score whereas in posttest they are having 4.02 score. Difference is 1.83. This difference is large and it is statistically significant difference.

Birth control method, in pretest, mothers are having 1.67 score whereas in posttest they are having 3.00 score. Difference is 1.33. This difference is large and it is statistically significant difference.

Significance of difference between pretest and posttest score was calculated using student paired t-test.

SECTION-C: EVALUATING THE EFFECTIVENESS OF STRUCTURED TEACHING PROGRAMME ON KNOWLEDGE OF SELECTED POST OPERATIVE SELF CARE IN THE STUDY GROUP.

TABLE 4.9: COMPARISON OF OVERALL PRE AND POST-TEST KNOWLEDGE SCORE BEFORE AND AFTER STP:

	No. of primi mothers	**Pretest Mean ± SD**	**Posttest Mean ± SD**	**Mean difference Mean ± SD**	**Student'S paired t-test**
Overall Knowledge Score	60	12.58 ± 3.92	23.47 ± 1.84	10.89 ± 4.28	t=19.68 P=0.001*** DF = 59, significant

*** Very high significant at P≤0.001

Table 4.9 shows the comparison of overall pretest and post test knowledge score before and after the administration of STP.

On an average, primi mothers were improved their knowledge from 12.58 to 23.47 after the administration of structured teaching programme. Considering overall knowledge score, in pretest primi gravida mothers are having 12.58 score where as in posttest they are having 23.47, so the difference is 10.89.The difference between pre - test and post-test score is large and it is statistically significant. Differences between pretest and posttest score was analysed using students paired, t'test

TABLE 4.10: DOMAINWISE PRETEST AND POSTTEST PERCENTAGE OF KNOWLEDGE

S. No	Domains	Posttest knowledge	Pretest knowledge	% of knowledge gain
1	General information on post-natal care	76.50%	35.00%	41.50%
2	Breast care	74.50%	38.67%	35.83%
3	Perineal care	81.25%	42.50%	38.75%
4	New born care	80.00%	44.44%	35.56%
5	Postnatal exercise	80.40%	43.80%	36.60%
6	Birth control method	75.00%	41.75%	33.25%
	TOTAL	78.23%	41.93%	36.30%

Table 4.10 shows each domain wise knowledge gain score among the primi mothers

TABLE 4.11: COMPARISON OF PRETEST AND POSTTEST LEVEL OF KNOWLEDGE SCORE

	Level of knowledge				Generalized McNemar's test
	Pretest		Posttest		
	n	%	n	%	
Inadequate knowledge	48	80.0%	0	0.0%	$\chi 2$=51.59 P=0.001***(S)
Moderate knowledge	12	20.0%	13	21.7%	
Adequate knowledge	0	0.0%	47	78.3%	
Total	**60**	**100.0%**	**60**	**100.0%**	

***significant at p<0.05 level**

- **Table 4.11** shows the pretest and post-test level of knowledge among women.
- Before STP, 80.0% of the primi mothers were having inadequate level of knowledge score, 20.0% of them having moderate level of knowledge score and none of them were having adequate level of knowledge score.
- After STP, none of the primi mothers were having inadequate knowledge and 21.7% of them having moderate knowledge and 78.3% of them were having adequate knowledge.
- Level of knowledge gain of between pretest and post test was calculated using Generalized McNemar's chi-square test.

SECTION-D: EVALUATE THE EFFECTIVENESS OF STRUCTURED TEACHING PROGRAMME IN ASSOCIATION BETWEEN KNOWLEDGE GAIN SCORE AND DEMOGRAPHIC VARIABLEST

Table 4.12: Effectiveness and generalization of structured teaching programme.

	Max score	**Mean score**	**Mean Difference of knowledge gain score with 95% Confidence interval**	**Percentage Difference of knowledge gain score with 95% Confidence interval**
Pretest	30	12.58	10.89(9.77 – 11.98)	36.30% (32.57% –39.93%)
Posttest	30	23.47		

Table 4.12 shows the effectiveness of structured teaching programme on knowledge of post-operative self care for primi para mothers undergoing elective caesarean section in Institute of Obstetrics and Gynaecology and Govt. Gospital for Women and Children, Egmore, Chennai-3.

On an average, in posttest after having STP, primi mothers were gained 36.30% more knowledge score than pretest score.

Differences and generalization of knowledge gain score between pretest and posttest score was calculated using and mean difference with 95% CI and proportion with 95% CI.

TABLE 4.13: ASSOCIATION BETWEEN POSTTEST LEVEL OF KNOWLEDGE AND THEIR DEMOGRAPHIC VARIABLES

Demographic variables		Post test Level of knowledge						N	Chi square test
		Inadequate		Moderate		Adequate			
		n	%	n	%	n	%		
Age	20 -23 years	0	0.0%	8	44.4%	10	55.6%	18	**$\chi 2=8.05$ P=0.01** (S)**
	24 -27 years	0	0.0%	4	13.8%	25	86.2%	29	
	> 27 years	0	0.0%	1	7.7%	12	92.3%	13	
Religion	Hindu	0	0.0%	10	20.4%	39	79.6%	49	$\chi 2=0.53$ P=0.76 (NS)
	Christian	0	0.0%	2	33.3%	4	66.7%	6	
	Muslim	0	0.0%	1	20.0%	4	80.0%	5	
Education qualification	Informal education	0	0.0%	4	20.0%	1	80.0%	5	**$\chi 2=11.90$ P=0.01**(S)**
	Primary education	0	0.0%	3	27.2%	8	72.8%	11	
	Middle education	0	0.0%	5	13.9%	31	86.1%	36	
	Higher secondary	0	0.0%	1	12.5%	7	87.5%	8	
Occupation status	Self employee	0	0.0%	3	50.0%	3	50.0%	6	$\chi 2=4.26$ P=0.23 (NS)
	Government	0	0.0%	0	0.0%	5	100.0%	5	
	Private	0	0.0%	2	20.0%	8	80.0%	10	
	Housewife	0	0.0%	8	20.5%	31	79.5%	39	
Monthly income	< Rs.5000	0	0.0%	1	14.3%	6	85.7%	7	$\chi 2=4.09$ P=0.25 (NS)
	Rs.5000-7000	0	0.0%	6	37.5%	10	62.5%	16	
	Rs.7000-12000	0	0.0%	5	20.8%	19	79.2%	24	
	> Rs.12000	0	0.0%	1	7.7%	12	92.3%	13	
Type of family	Nuclear family	0	0.0%	11	30.6%	25	69.4%	36	**$\chi 2=4.18$ P=0.05* (S)**
	Joint family	0	0.0%	2	25.0%	22	75.0%	24	
Living place	Rural	0	0.0%	7	41.2%	10	58.8%	17	**$\chi 2=5.31$ P=0.02* (S)**
	Urban	0	0.0%	6	13.9%	37	86.1%	43	
Age at menarche	11-13 yrs	0	0.0%	9	26.5%	25	73.5%	34	$\chi 2=2.59$ P=0.29 (NS)
	14-16 yrs	0	0.0%	3	12.5%	21	87.5%	24	
	17-19 yrs	0	0.0%	1	50.0%	1	50.0%	2	
Age at Marriage	16 -18 years	0	0.0%	2	33.3%	4	66.7%	6	$\chi 2=4.27$ P=0.23 (NS)
	19 -21 years	0	0.0%	2	12.5%	14	87.5%	16	
	22 -24 years	0	0.0%	6	18.8%	26	81.3%	32	
	> 24 years	0	0.0%	3	50.0%	3	50.0%	6	

Place of Antenatal visit	Hospital	0	0.0%	6	19.4%	25	80.6%	31	$\chi 2$=0.20 P=0.65 (NS)
	PHC	0	0.0%	7	24.1%	22	75.9%	29	
Pregnancy was Registered	Yes	0	0.0%	13	21.7%	47	78.3%	60	$\chi 2$=0.00P=1.00 (NS)
	No	0	0.0%	0	0.0%	0	0.0%	0	
Antenatal check up done by	Doctor	0	0.0%	6	17.6%	28	82.4%	34	$\chi 2$=1.37 P=0.50 (NS)
	Staff nurse	0	0.0%	5	23.8%	16	76.2%	21	
	Village health nurse	0	0.0%	2	40.0%	3	60.0%	5	
Source of Information	Parents	0	0.0%	9	28.1%	23	71.9%	32	$\chi 2$=2.05 P=0.56 (NS)
	Mass media	0	0.0%	1	9.1%	10	90.9%	11	
	Health professional	0	0.0%	2	20.0%	8	80.0%	10	
	No exposure	0	0.0%	1	14.3%	6	85.7%	7	

Table 4.13 shows the association between post-test level of knowledge and their demographic variables.

Regarding **age**, above 24years age group gained more knowledge about 92.3%. P value is 0.01. This is statistically significant.

Education wise, More educated mothers have gained (87.5%) more knowledge. P value is 0.01. This is statistically significant.

In family type, 75.0% knowledge gain in Joint family type. P value is 0.05. This is also statistically significant

Those who are living in urban area were gained more knowledge 86.1% than others. P value is 0.02. This is statistically significant.

So, Elder mothers, more educated mothers, Joint family mothers and urban mothers were gained more knowledge than others.

Statistical significance was calculated using pearson chi square test.

TABLE 4.14: ASSOCIATION BETWEEN KNOWLEDGE GAIN SCORE AND DEMOGRAPHIC VARIABLES

Demographic variables		Knowledge gain score						N	Chi square test
		Pretest		Posttest		Gain score= Post-Pre			
		n	%	n	%	n	%		
Age	20 -23 years	11.50	4.27	20.64	1.80	9.14	4.10	18	**F=3.16 P=0.05* (S)**
	24 -27 years	12.79	4.08	23.82	1.93	11.03	4.60	29	
	> 27 years	13.62	2.79	26.59	1.61	12.97	3.31	13	
Religion	Hindu	12.35	3.95	23.53	1.86	11.18	4.17	49	F=0.65 P=0.52 (NS)
	Christian	14.00	3.74	23.67	1.51	9.67	4.72	6	
	Muslim	13.20	4.21	22.60	2.07	9.40	5.27	5	
Education qualification	Informal education	14.40	4.98	22.10	3.00	7.70	3.98	5	**F=2.77 P=0.05*(S)**
	Primary education	11.18	4.62	20.30	1.54	9.12	3.97	11	
	Middle education	12.67	3.76	24.64	1.92	11.97	4.67	36	
	Higher secondary	13.00	2.93	25.83	.99	12.83	2.23	8	
Occupation status	Self employee	13.00	6.39	23.33	3.27	10.33	5.50	6	F=0.20P=0.89 (NS)
	Government	11.80	2.28	23.40	.89	11.60	2.19	5	
	Private	13.00	3.92	23.10	2.08	10.10	4.36	10	
	Housewife	12.51	3.76	23.59	1.63	11.08	4.38	39	
Monthly income	< Rs.5000	13.86	4.26	23.71	2.50	9.86	4.18	7	F=1.60P=0.19 (NS)
	Rs.5000-7000	12.06	3.19	22.81	2.10	10.75	4.43	16	
	Rs.7000-12000	13.46	4.00	23.54	1.61	10.08	3.71	24	
	> Rs.12000	10.92	4.15	24.00	1.41	13.08	4.84	13	
Type of family	Nuclear family	12.69	3.84	22.11	1.92	9.42	3.83	36	**t=2.12 P=0.04* (S)**
	Joint family	12.42	4.12	24.25	1.73	11.83	4.97	24	
Living place	Rural	11.82	4.69	21.03	1.75	9.21	4.06	17	**t=1.98 P=0.05* (S)**
	Urban	12.88	3.59	24.65	1.88	11.77	4.66	43	
Age at menarche	11-13 yrs	13.32	3.74	23.44	1.91	10.12	4.01	34	F=2.35 P=0.10 (NS)
	14-16 yrs	12.04	3.85	23.58	1.82	11.54	4.47	24	
	17-19 yrs	6.50	2.12	22.50	.71	16.00	2.83	2	
Age at Marriage	16 -18 years	10.00	3.16	22.67	1.63	12.67	2.42	6	F=0.74 P=0.53 (NS)
	19 -21 years	12.50	4.24	24.00	1.55	11.50	4.00	16	
	22 -24 years	12.91	3.91	23.41	2.03	10.50	4.79	32	
	> 24 years	13.67	3.50	23.17	1.60	9.50	3.51	6	

Place of Antenatal visit	Hospital	13.10	4.45	23.58	2.01	10.48	4.49	31	t=0.74 P=0.46 (NS)
	PHC	12.03	3.25	23.34	1.65	11.31	4.08	29	
Pregnancy was Registered	Yes	12.58	3.92	23.47	1.84	10.88	4.28	60	t=0.00P=1.00 (NS)
	No	.	.	.	.	.	.	0	
Antenatal check up done by	Doctor	12.74	4.08	23.59	2.03	10.85	4.10	34	F=0.07 P=0.92 (NS)
	Staff nurse	12.57	2.87	23.33	1.20	10.76	3.10	21	
	Village health nurse	11.60	6.80	23.20	2.86	11.60	9.13	5	
Source of Information	Parents	12.03	3.52	23.16	1.74	11.13	3.75	32	F=1.29 P=0.28 (NS)
	Mass media	12.73	4.92	23.82	2.04	11.09	4.61	11	
	Health professional	14.50	2.76	23.20	1.69	8.70	3.33	10	
	No exposure	12.14	5.21	24.71	1.89	12.57	6.63	7	

Table 4.14. shows the association between level of knowledge gain score and their demographic variables. Elder mothers, more educated mothers, Joint family mothers and urban mothers were gained more knowledge than others.

Statistical significance was calculated using one-way analysis of variance F-test and student independent t-test.

CHAPTER-V
DISCUSSION

This chapter deals with the discussion of the results of the data analyzed based on the objectives of the study and the hypothesis. The purpose of the study is to assess the **"**Effectiveness of structured teaching programme on knowledge of selected post-operative self care for primi mothers undergoing elective caesarean section in Institute of Obstetrics and Gynaecology and Govt. Hospital for women and children, Egmore, Chennai-3."

DISCUSSION

The study was carried out to assess the effectiveness of structured teaching programme on knowledge of selected post-operative self care for primi mothers undergoing elective caesarean section. The results of the study were based on the statistical analysis. The effectiveness of teaching programme was assessed by using Paired't' test. Chi-Square was used to find the association between the level of knowledge with selected demographic and obstetric variables.

The findings of the study are discussed below based on the study objectives

FINDINGS OF THE STUDY

Objective 1: To assess the level of knowledge on post-operative self-care among primi mothers undergoing Elective caesarean section

The percentage of pretest knowledge score in each domain wise. They are having maximum knowledge in New born care(44.44%) and 43.80%in Post natal exercise,42.50% in Perineal care, 38.67% in Breast care, 41.75% in Birth control method and minimum knowledge score in General information on post-natal care (35.00%). Overall pretest percentage of knowledge score is 41.93% among primi mothers.

The pretest level of knowledge on selected post operative self car**e** before administration of STP. In general, 80.0% (48) of the primi mothers are having inadequate knowledge and 20.0% (12) of them having moderate knowledge and none of them are having adequate knowledge.

The above findings were supported by the study,(**Savithri. 2011**) to assess the learning needs and self care practices regarding postnatal care among primi para mothers who underwent emergency LSCS. 40.8 percent of primi para women had adequate knowledge regarding post natal care so learning needs was 59.2 % on an average on post natal care. It was found that there was a significant positive moderate correlation between the learning needs and the self care practice of primipara mothers who underwent emergency LSCS The findings showed that half of mothers had adequate knowledge on postnatal care but poor self care practices and there is a significant relationship between the learning needs of primipara mothers on post natal care with the age, education and the area of residence.[40]

Objective 2: To identify the effectiveness of structure teaching in terms of gain in knowledge among primi mothers undergoing elective caesarean section.

A Structured teaching programme was conducted for 30-45 minutes. Posttest was conducted with the same questionnaire on 7th day

It was evident that the percentage of posttest knowledge scores on level of knowledge on post-operative self-care among primi mothers undergoing Elective caesarean section. It denotes that in post-test 81.25% of them having adequate knowledge in perineal care,80.40% of them having adequate knowledge in Post natal exercise,80.00%of them having adequate knowledge in New born care, 76.50%of them having adequate knowledge in General information on post-natal care, Overall post-test percentage of knowledge score is 78.23% among primi mothers.

The post-test level of knowledge on selected post operative self car**e** before administration of STP.78.3% (47) of them having adequate level of knowledge score, 21.7% (13) of them are having moderate knowledge score, None of the primi mothers are having inadequate knowledge score

It shows the comparison of overall knowledge score between pretest and posttest. On an average, in posttest, antenatal women gained 36.30% of knowledge score after having structured teaching programme on selected post operative self care. Differences between pre-test and post-test score were analyzed using proportion with 95% confidence interval and mean difference with 95% confidence interval. This

knowledge gain shows the effectiveness of structured teaching programme on selected post operative self care.

The above findings were supported by the study conducted by **Elizabeth Rajan (2008).** The study was conducted on Effectiveness of self instructional module on knowledge of post operative self care for mothers undergoing elective caesarean section in selected hospitals, Mangalore. Among the 11 areas, the mean percentage knowledge score in the area of caesarean section and self care was 77.50% bladder and bowel care was 60% breast feeding was 58.40% diet was 52.50% pain management was 47.50% post operative complications and home care was 46% baby care was 44.33% early ambulation and exercise was 44% perineal hygiene was 41% wound care was 40.67% and deep breathing and coughing was 40.67%.

To evaluate the effectiveness of structured teaching programme the pretest and posttest values are compared. The calculated 't' value is greater than the tabulated value at 5% level of significance. It shows that the teaching was effective.

Thus , H1 states, there is a significant difference between the pretest and post test level of knowledge on post operative self care among mothers undergoing caesarean section was accepted

Objective 3. To find the association between the pre test and post test level of knowledge on post operative self care among primi mothers undergoing elective caesarean section with selected demographic variables.

In considering the age, 24-27years age group gained knowledge score of 4.60%, 20-23 years age group gained knowledge score of 4.10%. P value is 0.05. This is statistically significant.

In considering education**,** more educated mothers have 4.67% knowledge gain score. P value is 0.05. This is statistically significant.

In family type, 4.97% knowledge gain score in Joint family type, and 3.83% knowledge gain score in joint family type. P value is 0.04. This is also statistically significant.

In urban living mothers are gained more knowledge4.66% than others. P value is 0.05. This is statistically significant.

Statistical significance was calculated using one-way analysis of variance F-test and student independent t-test.

The above findings were supported by the study, conducted by **Savithri (2011**) to assess the learning needs and self care practices regarding postnatal care among primi para mothers who underwent emergency LSCS. 40.8 percent of primi para women had adequate knowledge regarding post natal care so learning needs was 59.2 % on an average on post natal care. It was found that there was a significant positive moderate correlation between the learning needs and the self care practice of primipara mothers who underwent emergency LSCS The findings showed that half of mothers had adequate knowledge on postnatal care but poor self care practices and there is a significant relationship between the learning needs of primipara mothers on post natal care with the age, education and the area of residence.[40]

Thus the hypothesis H_2 which states that there is a significant association between the effectiveness of Structured teaching programme on knowledge on selected post operative self care among primi mothers undergoing elective caesarean section with selected demographic variables. So, Elder mothers, more educated mothers, Joint family mothers and urban mothers are gained more knowledge than others. None of the other variables are significant. Hence the H_2 was accepted.

CHAPTER-VI

SUMMARY, CONCLUSION AND IMPLICATION, RECOMMENDATION

This chapter deals with summary, Conclusion, Implications, Recommendations and Limitations of the study.

6.1. SUMMARY:

The study was conducted in Institute of Obstetrics and Gynaecology and Govt. hospital for women and children, Egmore, Chennai-3 for a period of 4 weeks from 02.01.18 to 28.01.18. The aim of the study was to assess the level of knowledge on post-operative self-care among primi mothers undergoing elective caesarean section before and after giving the Structured Teaching Program. A conceptual framework for this study was adapted by J. W. Kenny's general system model. The first part of the study was involved with instruments developed based on the findings from a quantitative study. Semi-structured questionnaires were developed. A pilot study was done to assess the feasibility of the study and necessary changes were adopted. After a pilot study, reliability of the tool was assessed by using Test-retest method. Knowledge score reliability correlation coefficient value is 0.80. The investigators were chosen pre experimental study, one group pre test and post-test design. The subjects were selected using purposive sampling technique among primi gravida mothers undergoing elective caesarean section. Subject's knowledge was assessed before giving the planned teaching program

6.2. MAJOR FINDING OF THE STUDY

6.2.1 **Based on demographic findings**

The study findings revealed the following demographic and obstetric characteristic features of 60 primi mothers who participated in the study.

- **According to Age** wise distribution, 48.3% (29) were in the age group of 24 – 27 years. 30.0% (18) were in the age group of 20 -23 years, 21.7%(13) were in the age group of > 27 years.

- In **religion**, 81.7% (49) belongs to Hindu religion, 10.0% (6) belongs to Christian and remaining 8.3% (5) are of Muslim religion.

- In **education** wise, 60.0% (36), had Higher secondary education, 18.4% (11) had primary education, 13.3% (8) were graduates 8.3% (5) were had Informal education

- **Job** wise, 65.0% (39) were house wife, 16.7% (10) were worked in private sector, 16.7% (6) of them had self job, and only 8.3% (5) were in Government jobs.

- In the **monthly income** 40.0% (24)) family monthly income was between Rs.7000-12000and 26.6% (16) monthly income was Rs.5000-7000, 21.7% (13) income was > Rs.12000, 11.7% (7) income was < Rs.5000

- In **family type**, 60% (36) were in nuclear family and remaining 40% (24) were in joint family.

- In living place, 71.7% (43) came from Urban, 28.3% (17) came from rural.

- In **age at marriage**, 53.3% (32) were married at the age of 22-24 years, and 26.7% (16) were married at the age of 19-21 years, 10.0% (6) were married at the age of > 24 years, 10.0% (6) were married at the age of 16 -18 years.

- In Age at menarche, 56.7% (34) attained at age of 11-13 yrs, 40.0%(24) at age of 14-16 yrs, 3.3%(2) attained at age of 17-19 yrs

- In **Place of Antenatal visit** 51.7%(31) visited in Hospitals, 48.3%(29) visited in PHC

- 100.0% Pregnancy was Registered

- ❖ 56.7% Antenatal check up done by Doctor, remaining done by nurses
- ❖ 53.3% (32) got informations of selected self care from parents.

6.2.2 **Based on Pre-test knowledge of primi mothers in the study group**

The percentage of pretest knowledge score in each domain wise. They were having maximum knowledge in **New born care** (44.44%) and 43.80% in Post natal exercise, 42.50% in Perineal care, 38.67% in Breast care, 41.75% in Birth control method and minimum knowledge score in **General information on post-natal care** (35.00%). Overall they were having 41.93% of score.

The pretest level of knowledge on selected post operative self car**e** before administration of STP. In general, 80.0% (48) of the primi mothers are had inadequate knowledge and 20.0% (12) of them had moderate knowledge and none of them are having adequate knowledge.

6.2.3: **Based on post-test knowledge of primi mothers on selected post operative self crae in the study group**

Each domain wise post-test percentage of knowledge on post operative self care among primi mothers undergoing Elective caesarean section. They were having maximum knowledge in **perinea care** (81.25%), 80.40% knowledge in Post natal exercise, 80.00% knowledge in New born care, 76.50% knowledge in General information on post-natal care, 74.50% knowledge in Breast care and minimum knowledge score in **Breast care** (74.50%). Overall they are having 78.23% of score.

The post-test level of knowledge on selected post operative self car**e** before administration of STP. 78.3% (47) of them having adequate level of knowledge score , 21.7%(13) of them were having moderate knowledge score, None of the primi mothers were having inadequate knowledge score.

6.2.4: **Based on the effectiveness of structured teaching programme on knowledge of selected post-operative self care in the study group**

Considering Knowledge regarding **General information on post-natal care**, in pretest, mothers are having 0.70 score whereas in posttest they are having 1.53 score. Difference is 0.83. This difference is large and it is statistically significant difference.

Considering **Breast care**, in pretest , mothers are having 2.32 score whereas in posttest they are having 4.47 score. Difference is 2.15This difference is large and it is statistically significant difference.

Considering **Perineal care**, in pretest, mothers are having 1.70 score whereas in posttest they were having 3.25 score. Difference is 1.55. This difference is large and it is statistically significant difference.

Considering **New born care**, in pretest, mothers were having 4.00 score whereas in posttest they were having 7.20 score. Difference is 3.20. This difference is large and it is statistically significant difference.

Considering **Post natal exercise**, in pretest, mothers were having 2.19 score whereas in posttest they were having 4.02 score. Difference is 1.83. This difference is large and it is statistically significant difference.

Considering **Birth control method**, in pretest, mothers were having 1.67 score whereas in posttest they were having 3.00 score. Difference is 1.33. This difference is large and it is statistically significant difference.

Significance of difference between pretest and posttest score was calculated using student paired t-test.

The comparison of over all knowledge before and after the administration of STP. On an average, primi mothers were improved their knowledge from 12.58 to 23.47 after the administration of structured teaching programme. Or we can say, in pretest they were able to answer only 12 questions before administration of STP, after

administration of STP they were able to answer upto23 questions. Due to VAT they were able to answer 11 more questions correctly. This difference is statistically significant. Statistical significance was calculated by using student's paired 't'test.

In post-test, none of the antenatal women were having inadequate knowledge score, 21.6% of them having moderate knowledge score, 78.4% of them were having adequate level of knowledge score.

Statistically there is significant difference between pretest and posttest knowledge score.

Each domain wise percentage of knowledge gain. 41.50% of knowledge gain in General information on post-natal care, 35.83% knowledge gain in Breast care, 38.75% knowledge gain in Perineal care and 35.56% of knowledge gain in New born care , 36.60% knowledge gain in Postnatal exercise, 33.25% knowledge gain in Birth control method. Overall they gained 36.30%of knowledge score when comparing pretest and posttest after having STP. This shows the effectiveness of STP on knowledge of selected postoperative self care among primi mothers undergoing elective caesarean section

6.2.5. **Based on association between posttest score with selected demographic and Obstetrical variables**

In considering the **age**, 24-27years age group gained knowledge score of 4.60%, 20-23 years age group gained knowledge score of 4.10%. P value is 0.05. This is statistically significant.

In considering **education,** More educated mothers have 4.67% knowledge gain score. P value is 0.05. This is statistically significant.

In **family type,** 4.97% knowledge gain score in Joint family type, and 3.83% knowledge gain score in joint family type. P value is 0.04. This is also statistically significant

In **urban living** mothers are gained more knowledge4.66% than others. P value is 0.05. This is statistically significant.

Statistical significance was calculated using oneway analysis of variance F-test and student independent t-test.

6.3. IMPLICATION:

The present study was used to assess the effectiveness of structured teaching programme on post operative self care among primi mothers undergoing elective caesarean section.

6.3.1 Implications of the study

The investigator has drawn the following implication for the study which is vital concern in the field of nursing practice, nursing education, nursing administration and nursing research.

Some of the implications for the present study in various areas as follows:

6.3.1 Nursing practice

- The findings of the study could be utilized as basis for providing education for primi mothers so that constant awareness and clear understanding may be created among the primi mothers regarding post operative self care
- It serves as a guideline for nurses to identify the area where the mothers are lacking in their knowledge thereby providing special attention to that area. while educating the mothers to demonstrate the practices on self caring and maintenance of personal hygiene, perineal hygiene and breast hygiene, new born care, birth control measures and early postnatal exercise .so that misconceptions and wrong practice of post natal care can be avoided.
- Continuing nursing programme on post natal self care after elective LSCS can be organized

- ❖ Nurse should assist the primi mother to take self care by creating awareness about post natal care after surgery in the post natal period itself.

6.3.2 Nursing education

- ❖ Conferences, workshops and seminars can be held for impart, to update the knowledge and positive attitudes.
- ❖ In-service education updating their knowledge and skill in various health care settings can be given.
- ❖ Nursing curriculum has to focus on enabling the nursing students to develop skill in identifying risk groups and prevent the complications.
- ❖ Every Students may be given chance to practice and give health education on post natal care among pimi mothers subjected to cesarean section.
- ❖ Short term courses can be organized for the nurses, who are working in obstetrical unit.
- ❖ Appropriate audio – visual aids can enhance the art and skill of teaching proper post natal care among primi gravid mothers.

6.3.3 Nursing administration

The present study is proposed to help the health administrators to strategically plan and meet the health needs of the primi gravida mothers

- ❖ The administrators in both private and government sectors should take initiative actions to update the knowledge of primi mothers on post operative self care.
- ❖ The administrator can encourage the nurses for conducting research in various aspects of post natal care.
- ❖ The administrator can organize conference, workshop and seminars for nurses working in the community.

- It highlights the need for nurse administrators to formulate policies and guidelines for health education and demonstrate regarding the postnatal care to mothers

- The nursing administration should awaken to the fact that patient education is a necessity and should provide resources in terms of manpower, money and material. Nursing research

- The study will be a valuable reference material for further researchers.

- Nursing conference and in service programme can be conducted regarding early ambulation for mothers subjected to caesarean section

6.3.4 NURSING RESEARCH

- The effectiveness of the study can be verified by its utility by the nurse in the practical field

- Research can be promote many studies on this topic among varies patients

- The nurse can be motivated by the nursing educator and administrator to conduct research on knowledge about post operative self care following LSCS

- Research on knowledge, attitude and selected practice on postnatal care can reveal clinically significant findings. Use of research findings should become part of quality assurance evaluations to enhance individual profession as a whole. There is still lot of scope for exploring more on this topic.

6.4 LIMITATIONS

- The study was limited to primi gravida mothers undergoing elective LSCS

- The sample size was small.

- The duration of the study was 4 weeks.

6.5 RECOMMENDATIONS FOR FURTHER STUDY

On the basis of findings it is recommended that,

- The study can be repeated by taking a large sample which would enable the researcher to generalize the findings.
- A comparative study can be conducted between primi gravida mothers and multi gravida mothers undergoing elective LSCS.
- A comparative study regarding post natal care can be conducted between vaginal delivery mothers and LSCS mothers.
- The study can be conducted alone regarding early ambulation following surgery in different setting A comparative study can be conducted between literate and illiterate mothers

6.6 CONCLUSION

This study showed that the primi gravid mothers had high knowledge regarding post operative self care after STP. They had adequate knowledge about new born care, perineal care, birth control methods but had poor knowledge in the aspect of post natal period, postnatal exercise and breast care. Teaching created self care awareness during hospital stay. The overall self care knowledge was moderate and poor. Import knowledge regarding postnatal care during antenatal period can make them to perform the self care practices well and improve maternal and newborn health. It will prevent postnatal complications and minimizes the hospital stay.

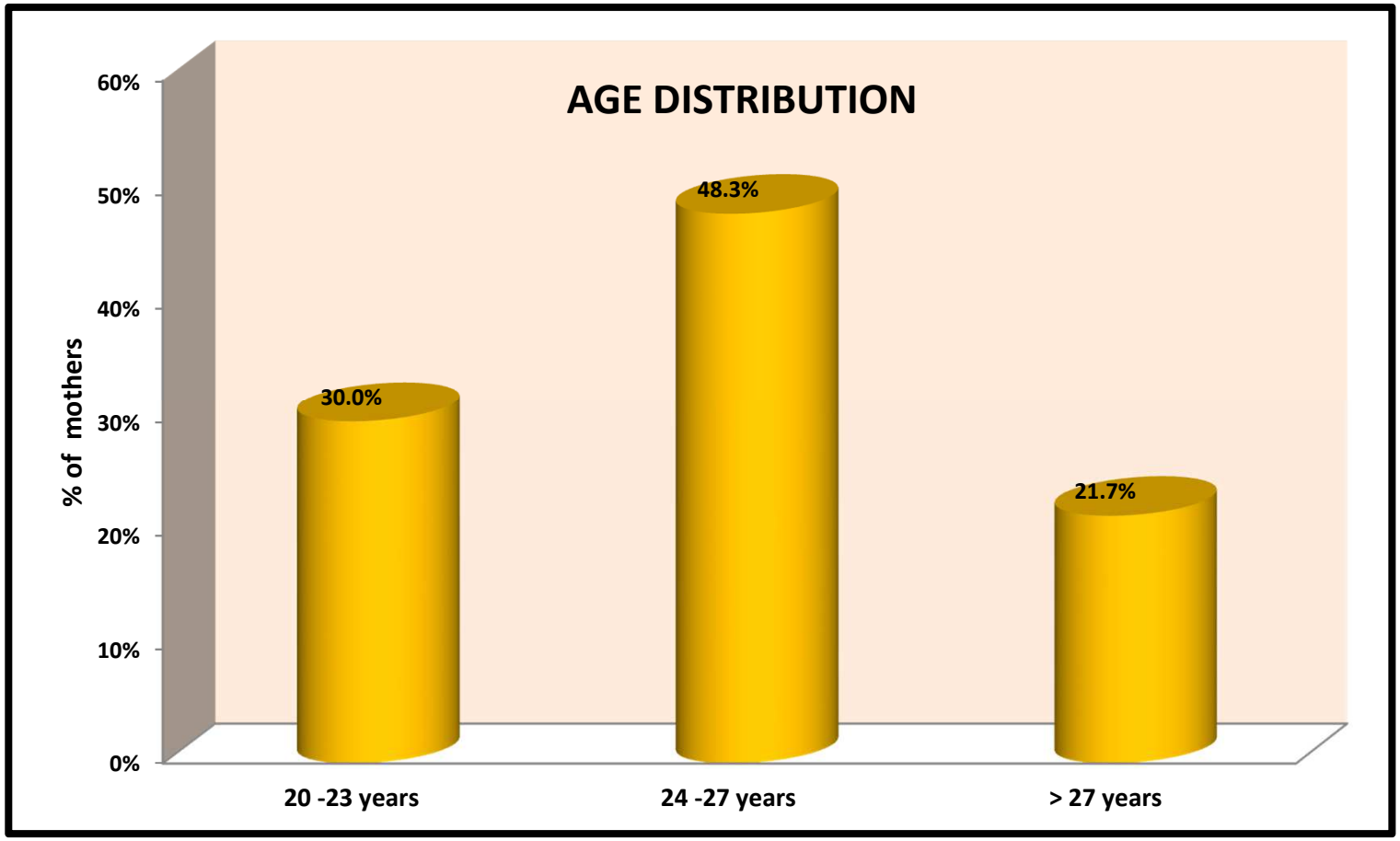

Figure 4.1 – Percentage distribution of age of mothers

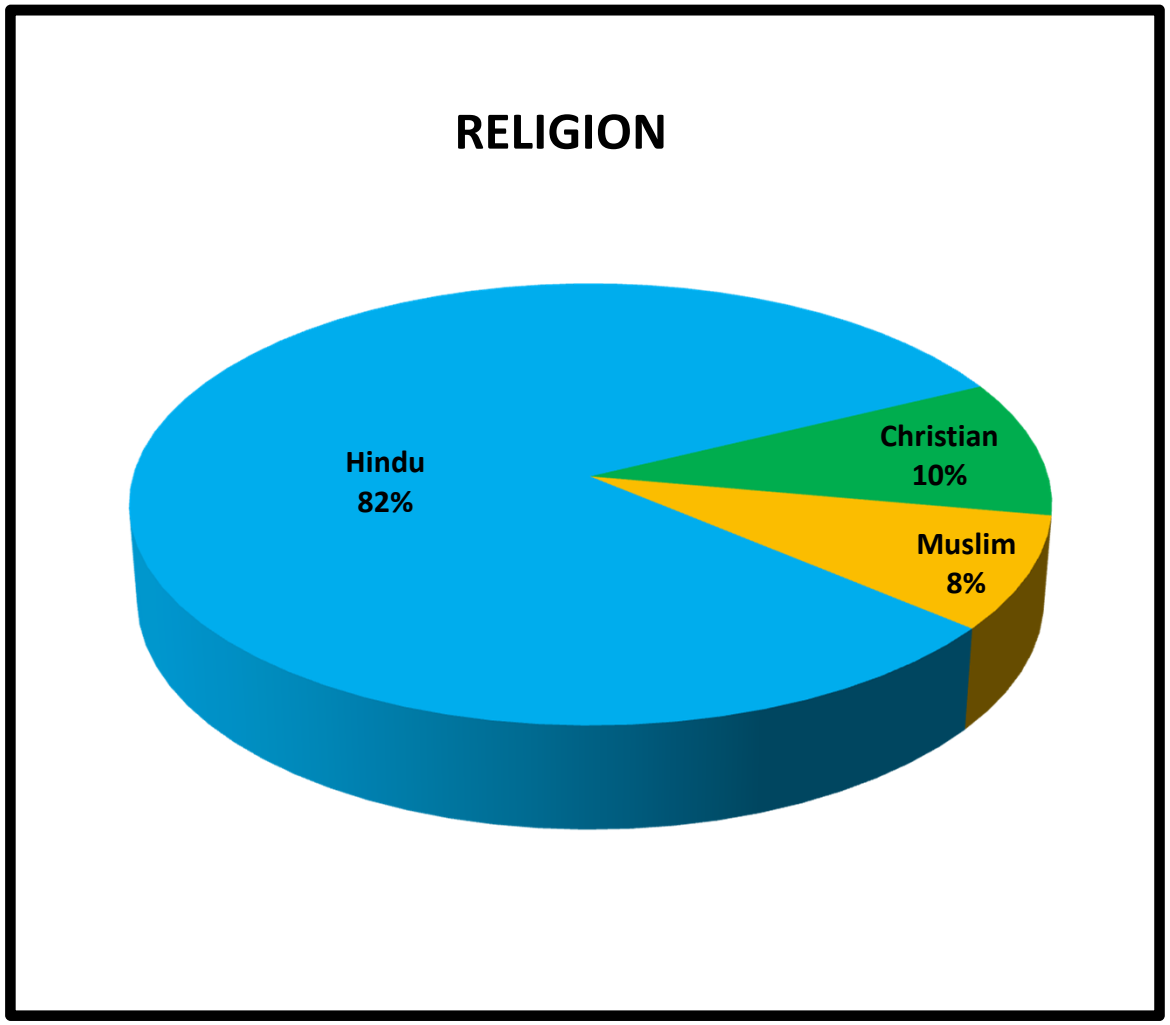

Figure 4.2 – Percentage distribution of religion of mothers

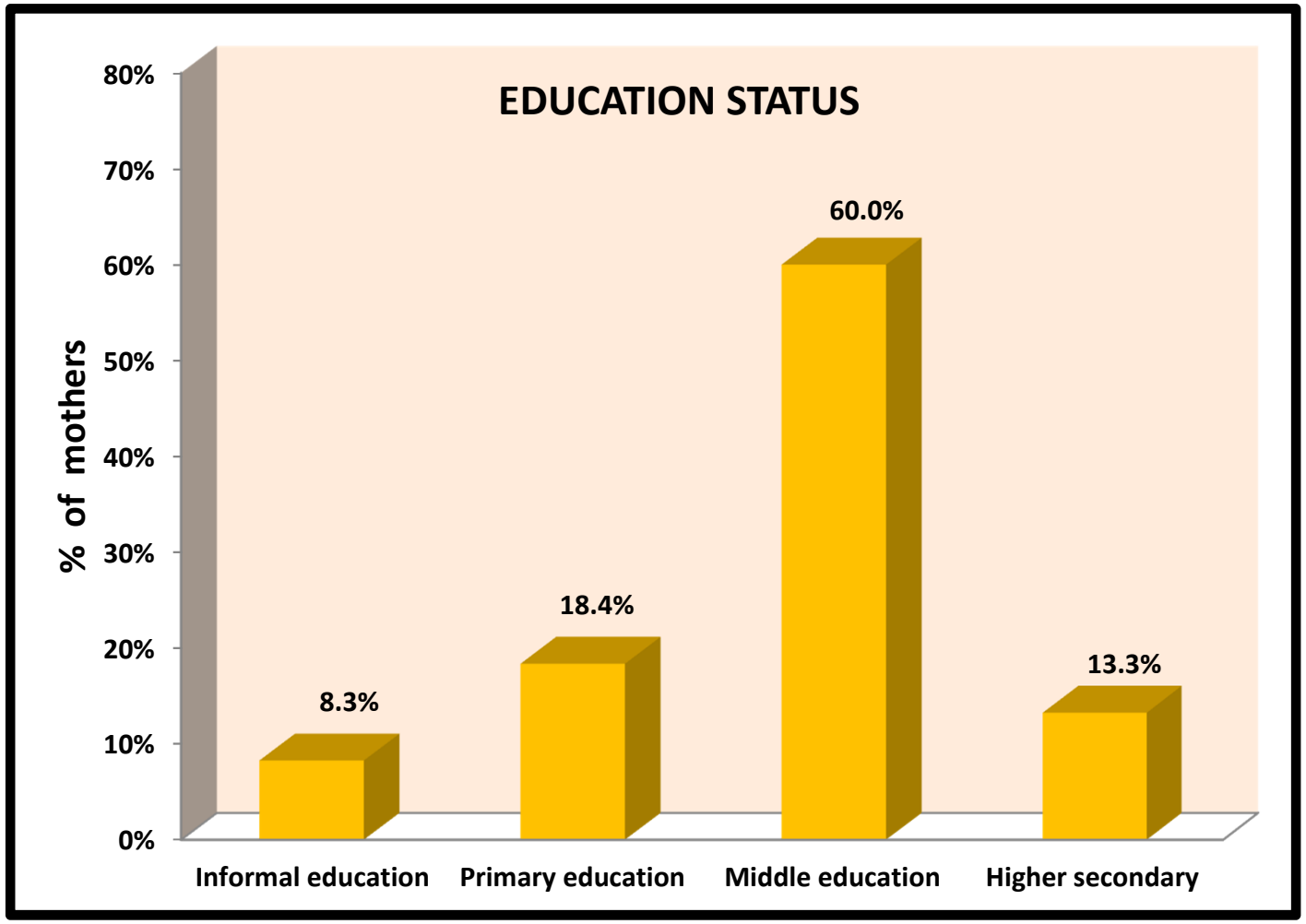

Figure 4.3 – Percentage distribution of education status of mothers

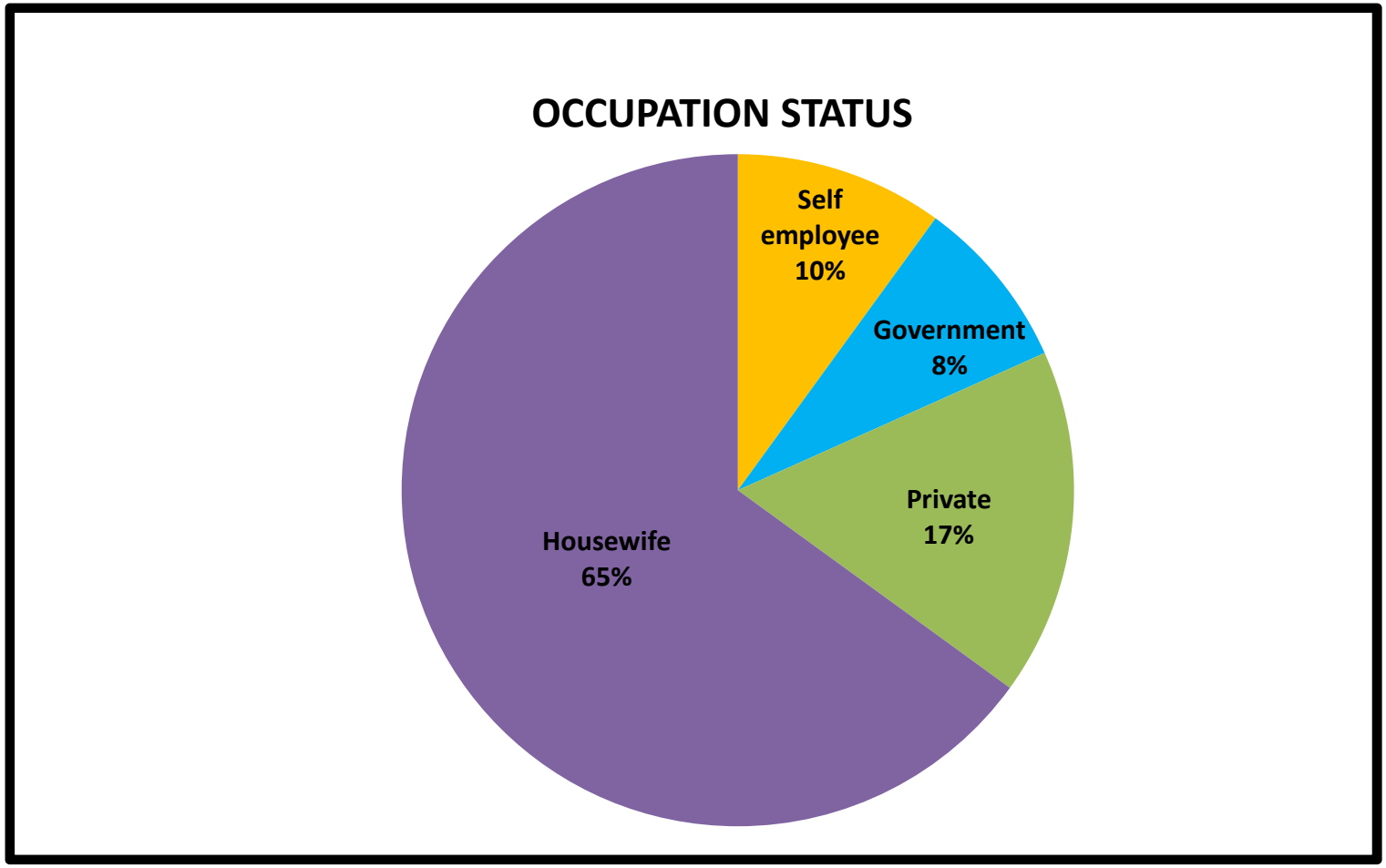

Figure 4.4– Percentage distribution of occupation of mothers

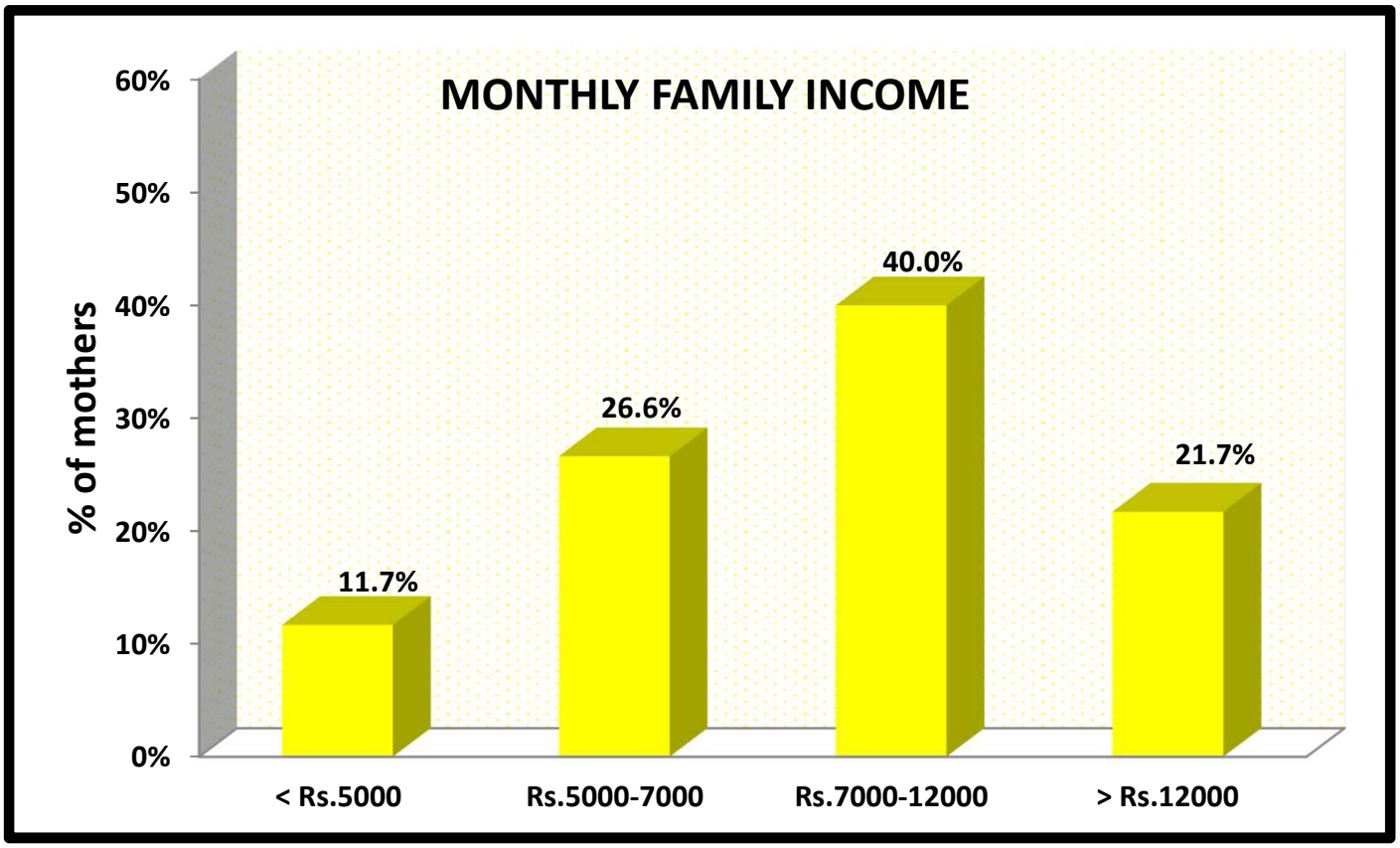

Figure 4.5 – Percentage distribution of monthly income of family

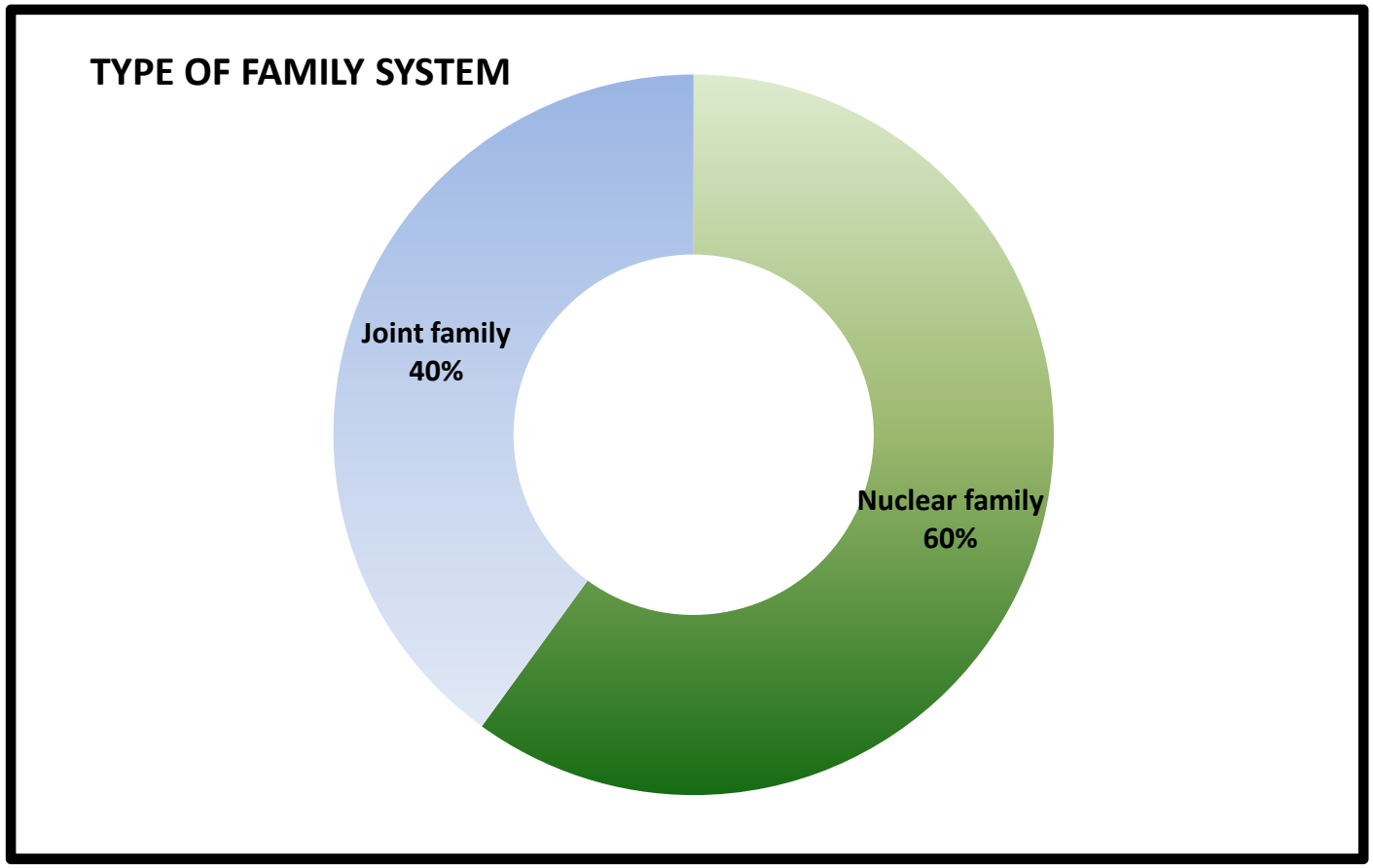

Figure 4.6– Percentage distribution of type of family of mothers

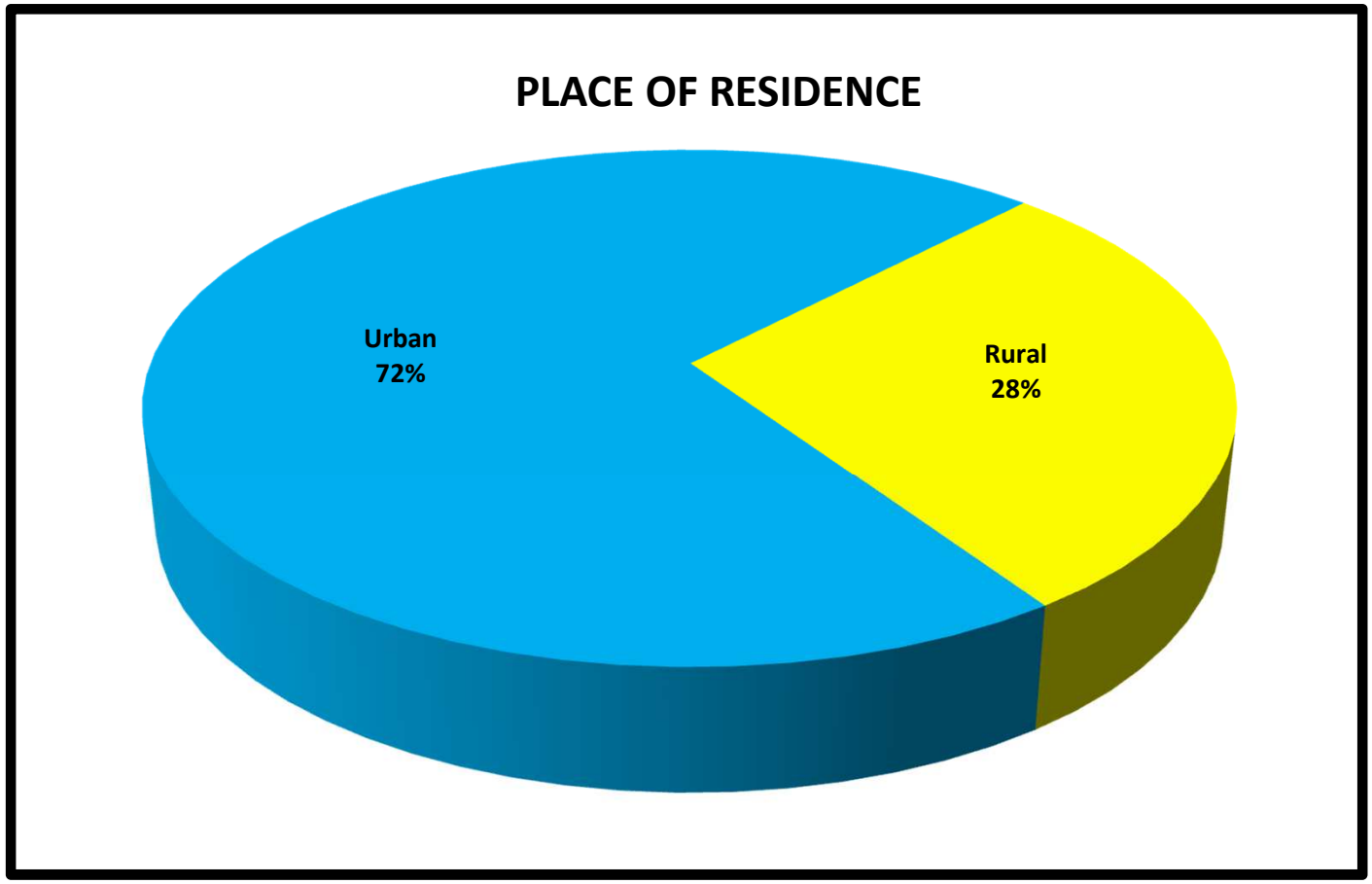

Figure 4.7 – Percentage distribution of place of residence of mothers

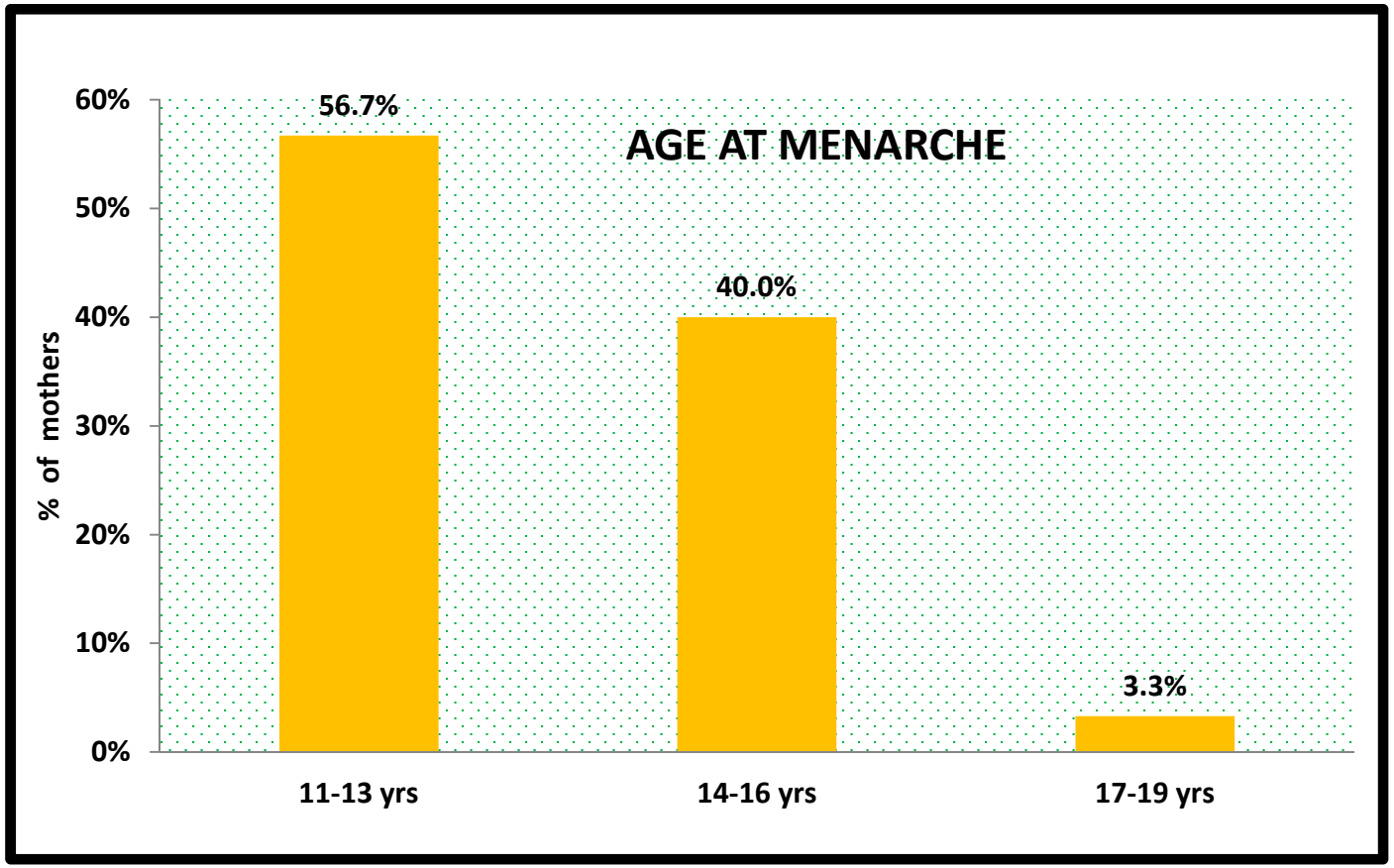

Figure 4.8– Percentage distribution of age at menarche of mothers

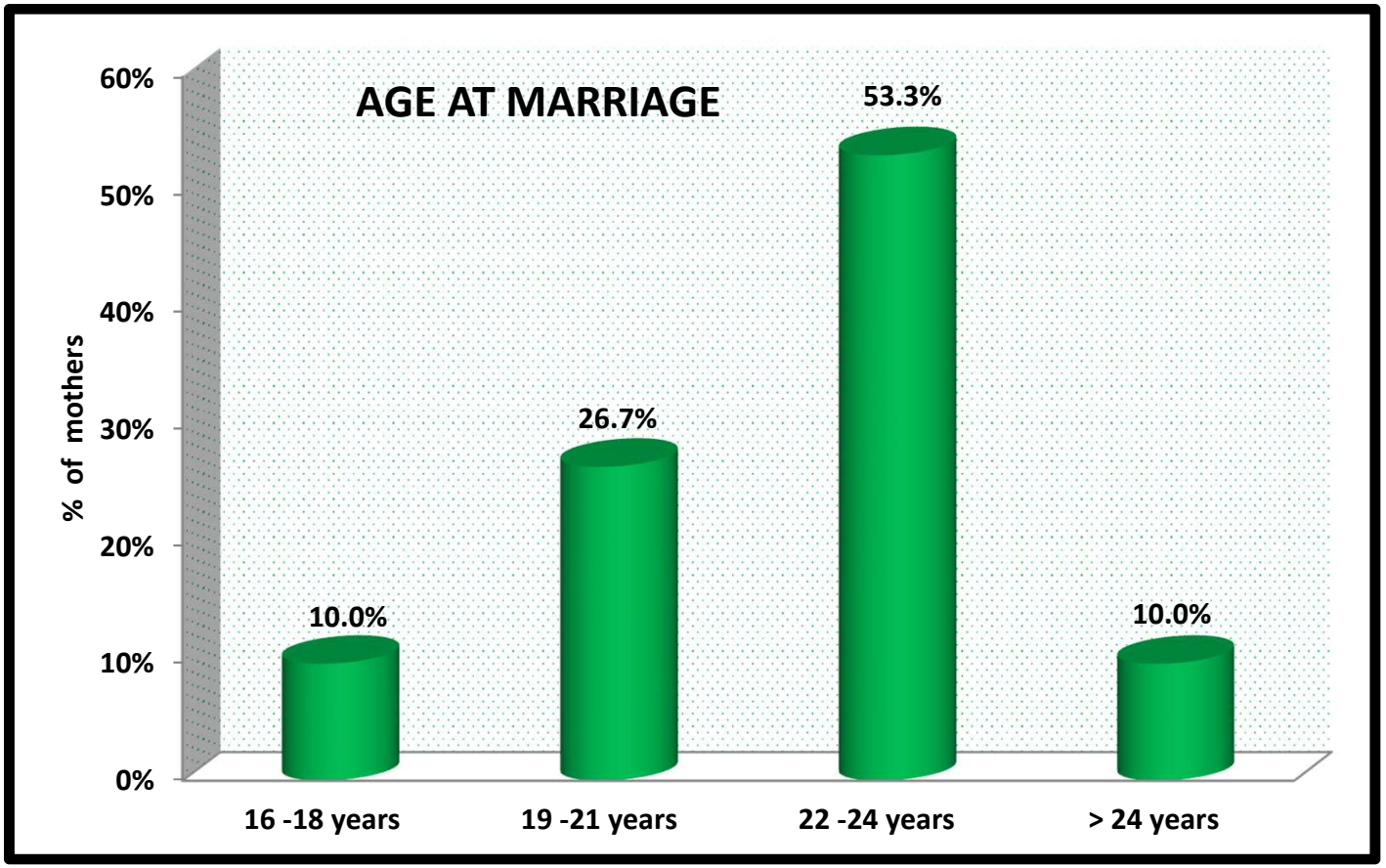

Figure 4.9– Percentage distribution of age at marriage of mothers

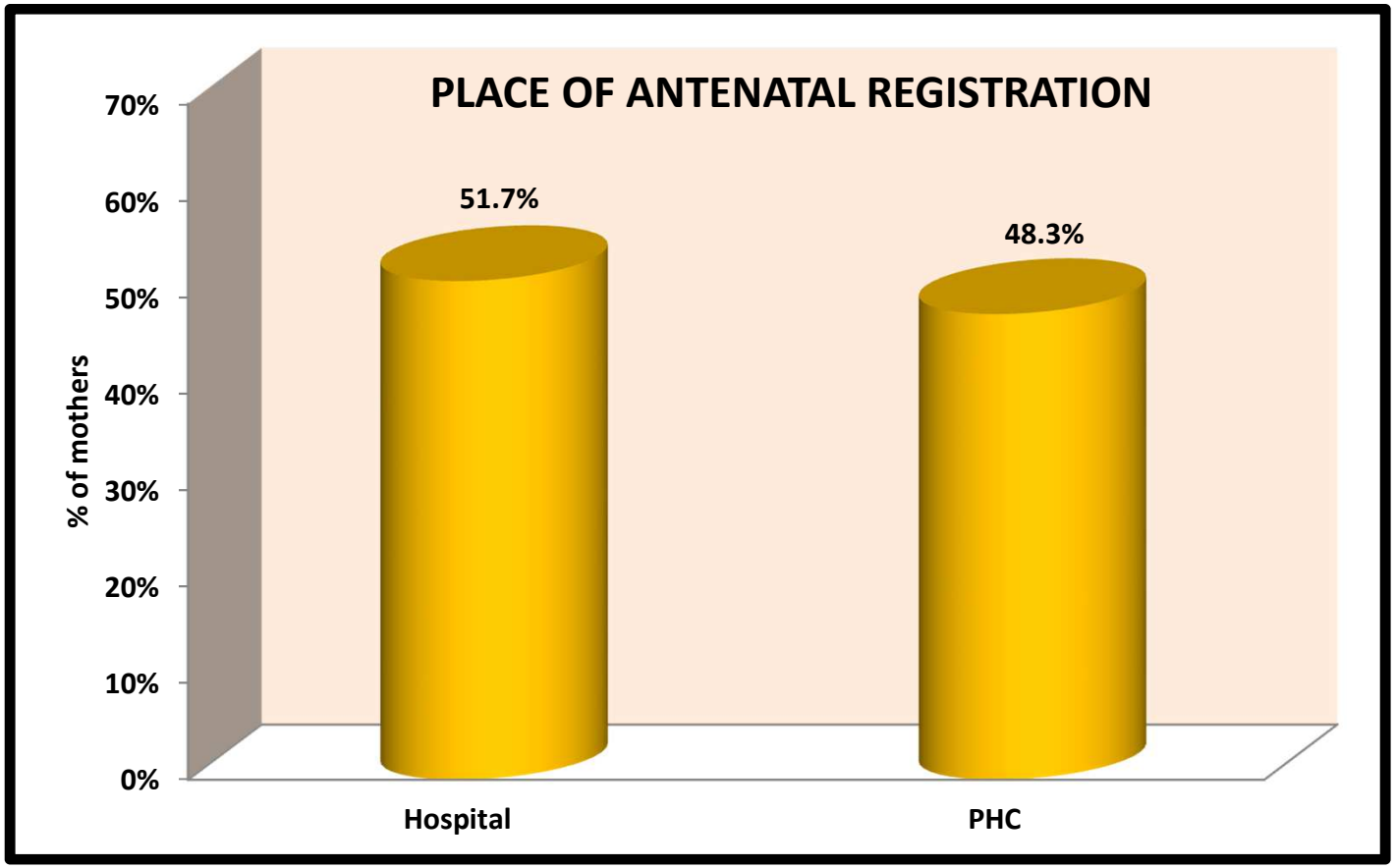

Figure 4.10 – Percentage distribution of place of antenatal registration

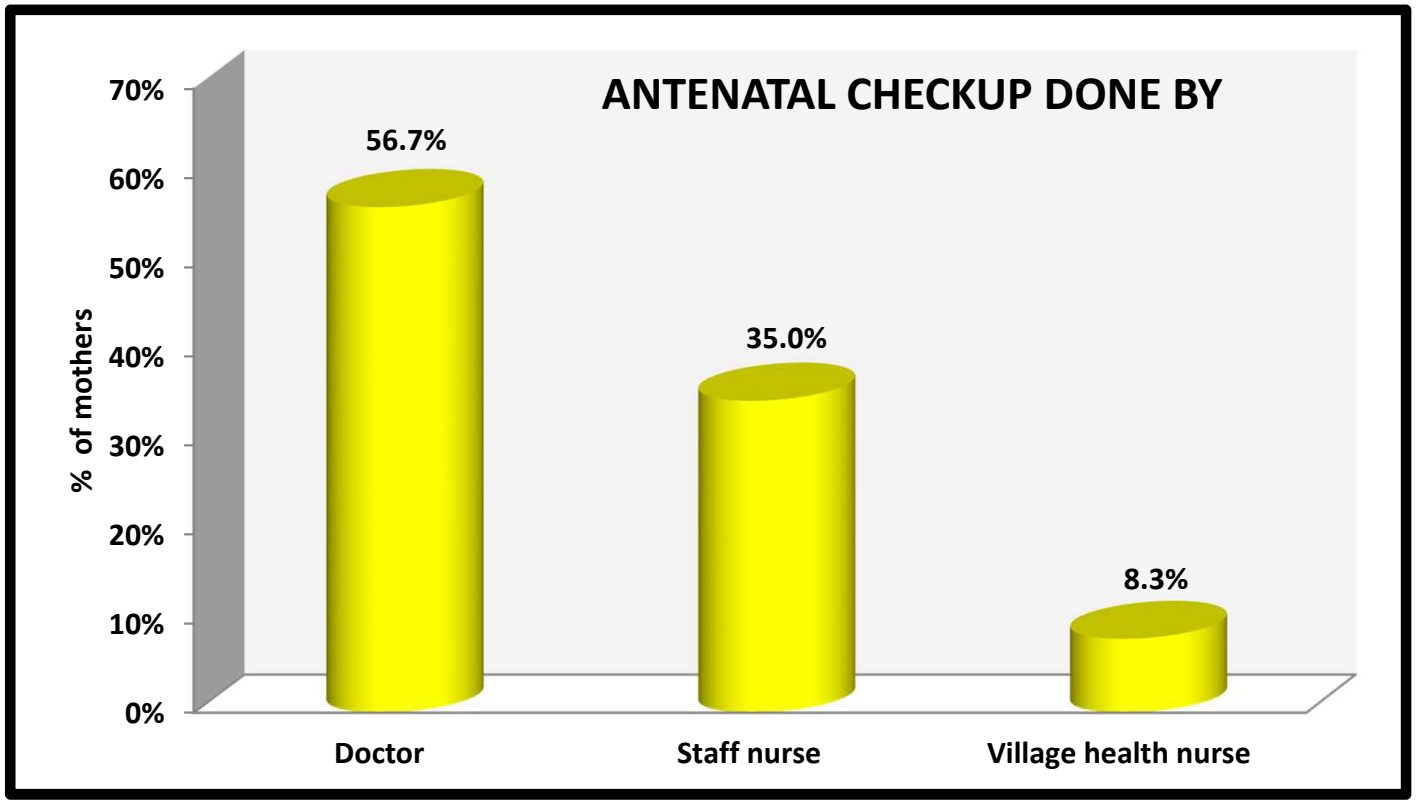

Figure 4.11 – Percentage distribution of antenatal checkup done

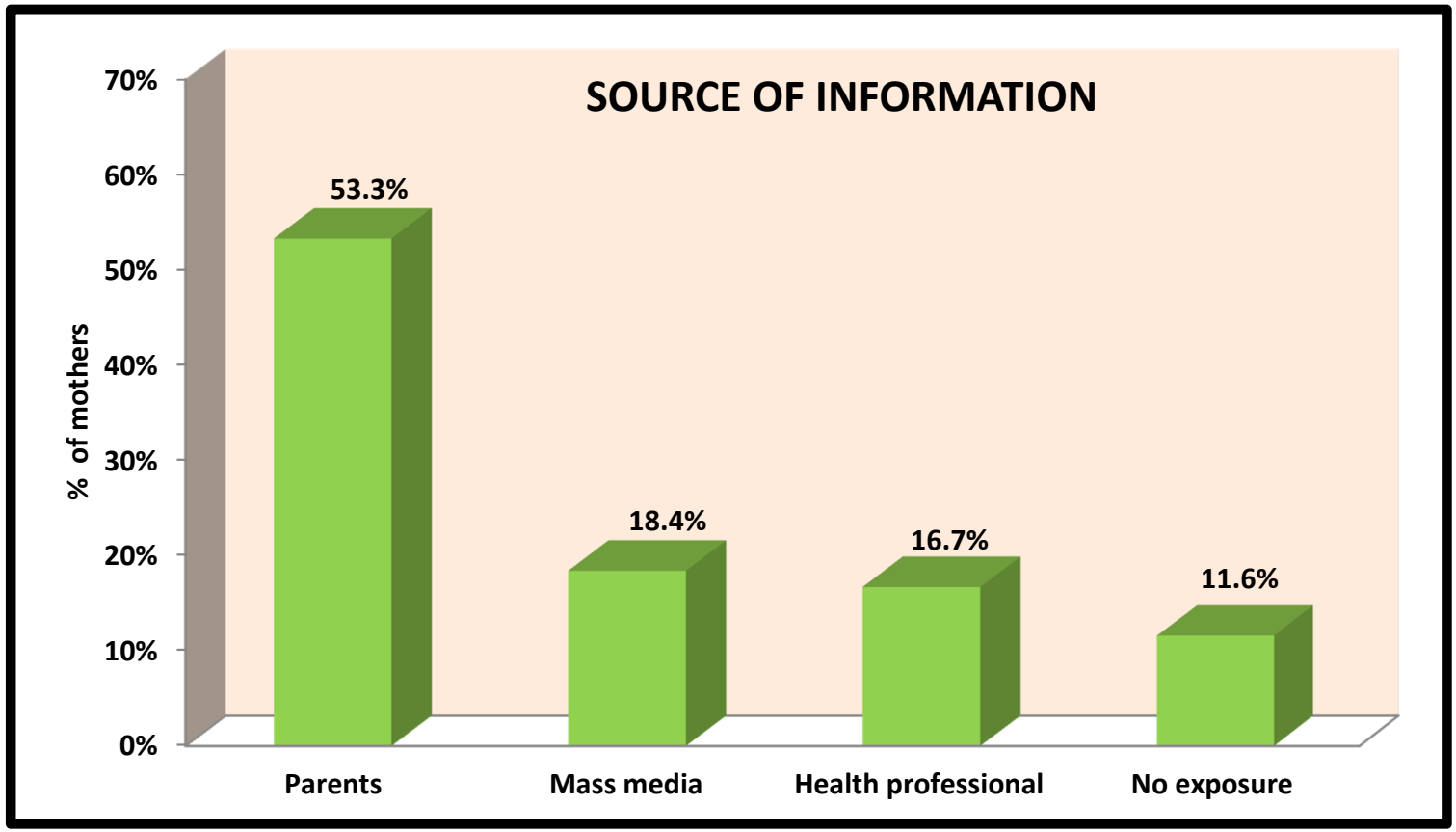

Figure 4.12– Percentage distribution of source of information

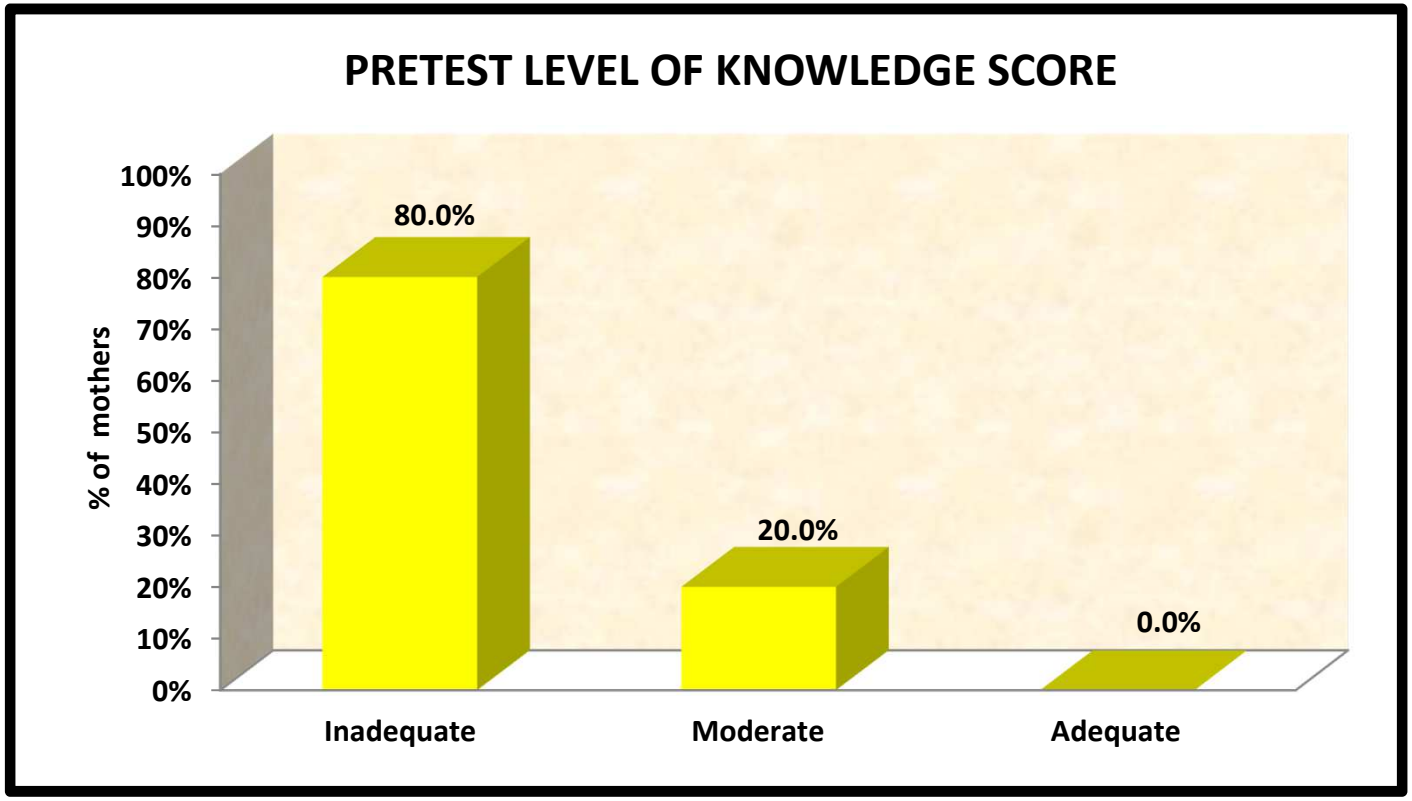

Figure 4.13– Percentage distribution of pretest level of knowledge score

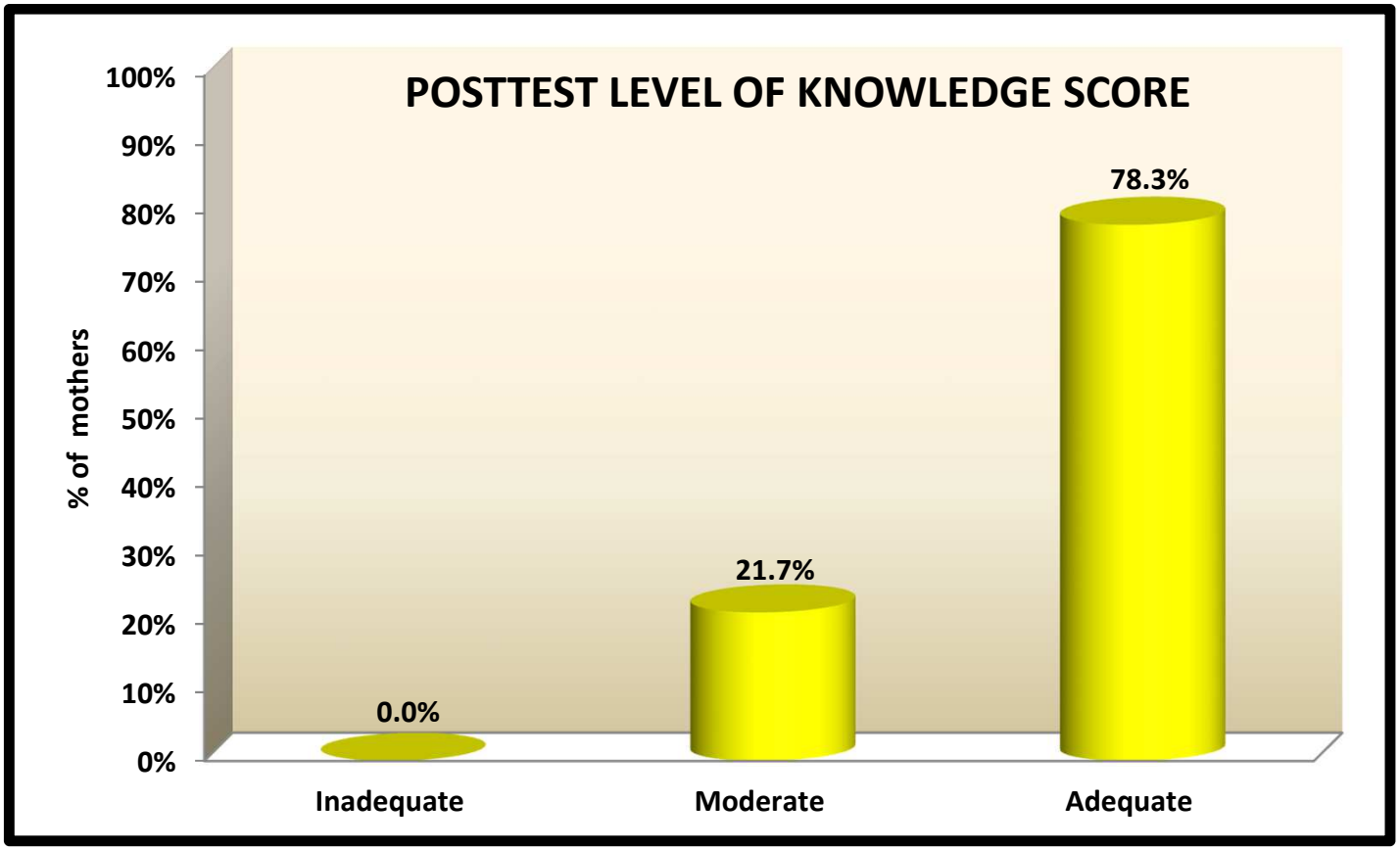

Figure 4.14– Percentage distribution of post test level of knowledge score

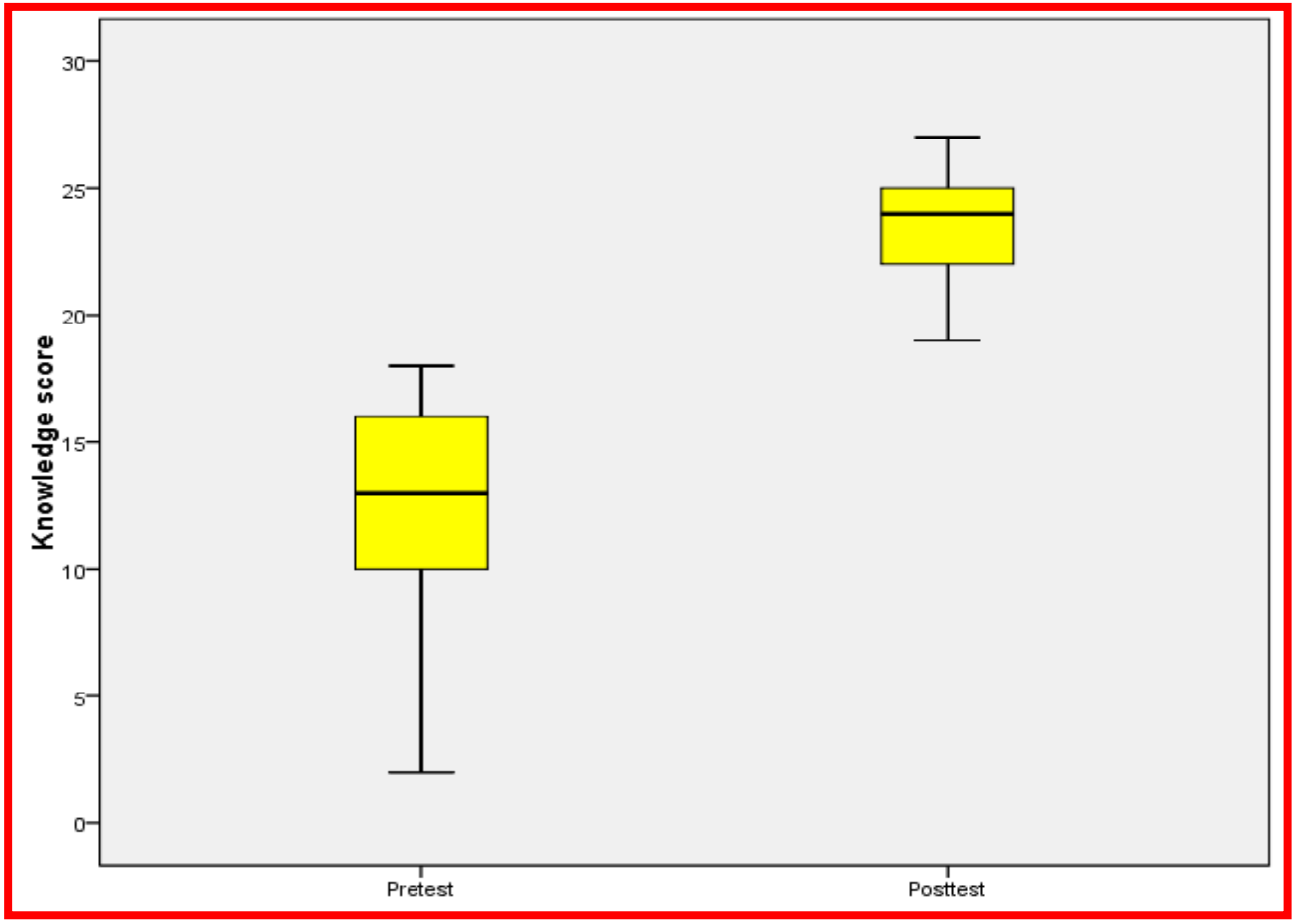

Fig 15: Box Plot Compares the mothers pretest and posttest knowledge score

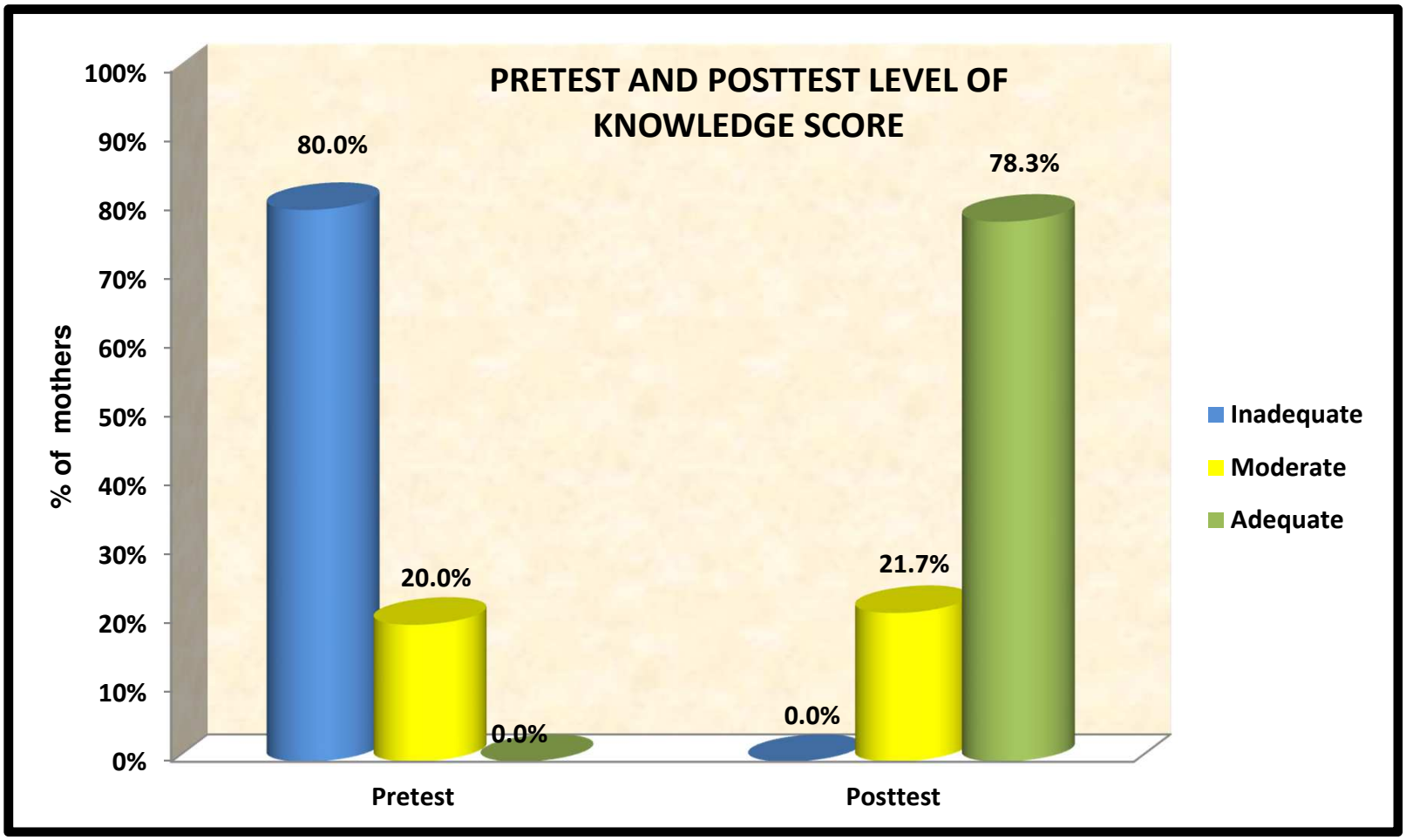

Figure 4.16– Percentage distribution of pre test and post test level of knowledge score

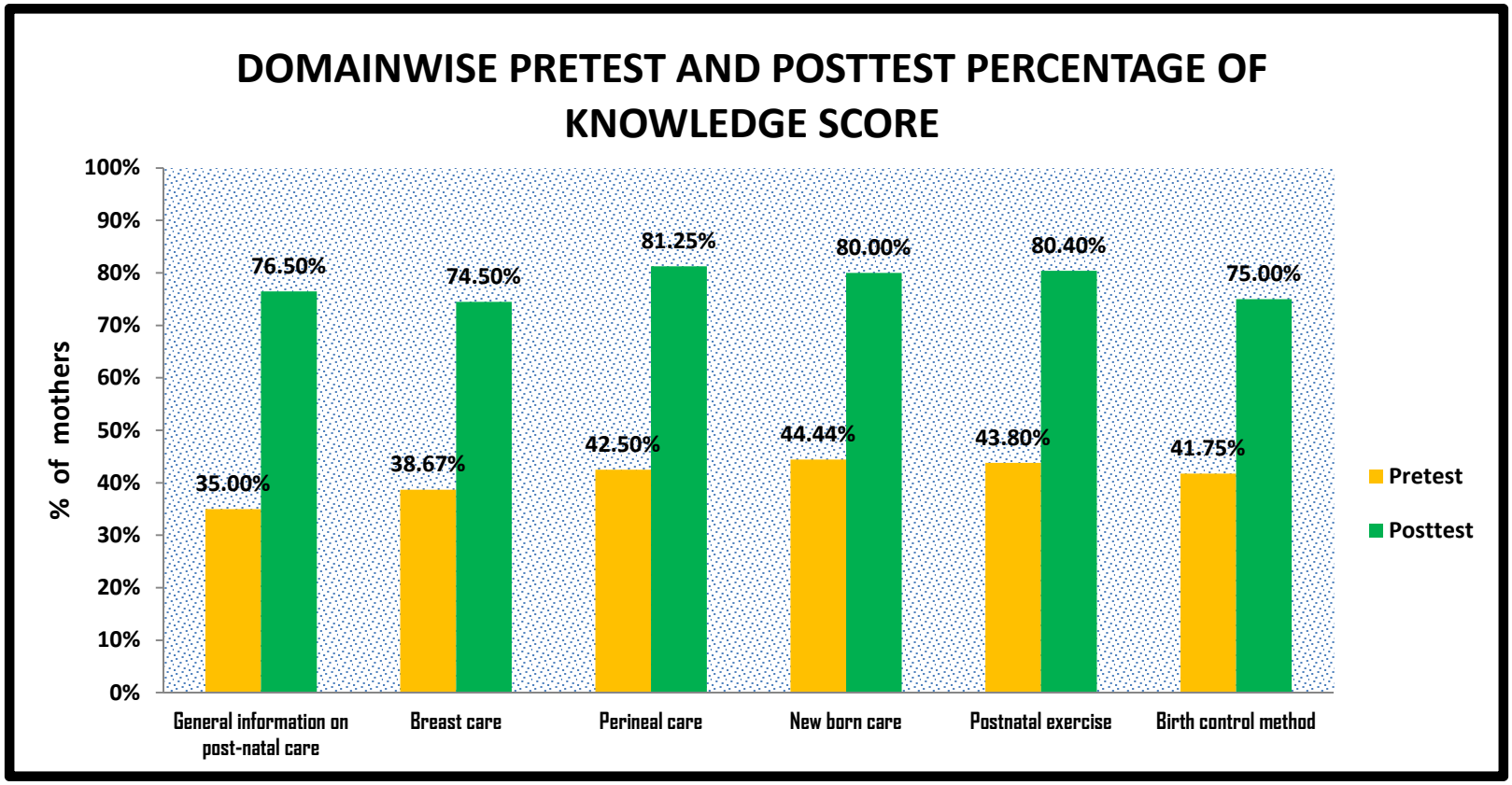

Figure 4.17– Percentage distribution of pre test and post test level of knowledge score

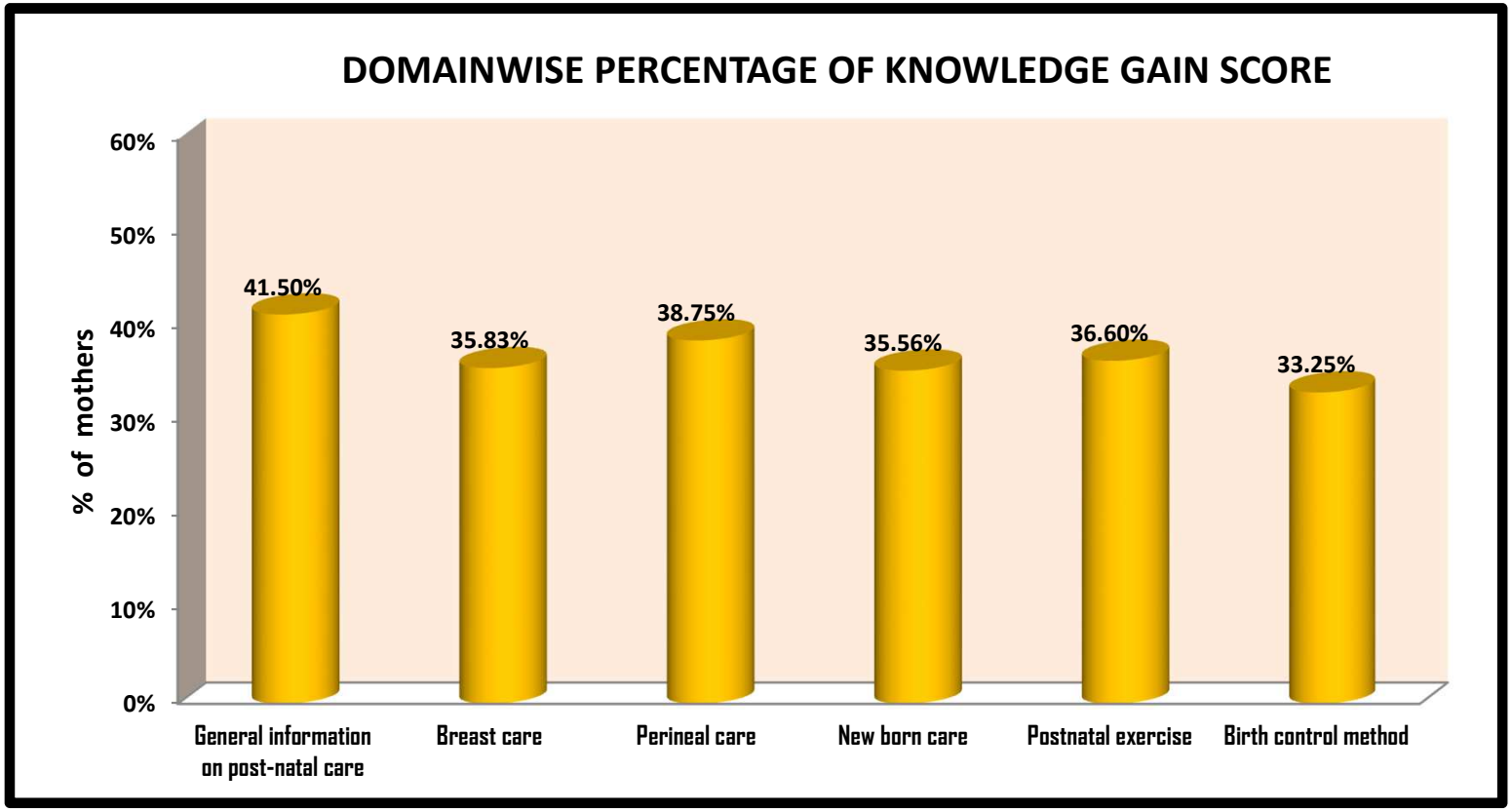

Figure 4.18– Percentage distribution of domain wise knowledge gain score

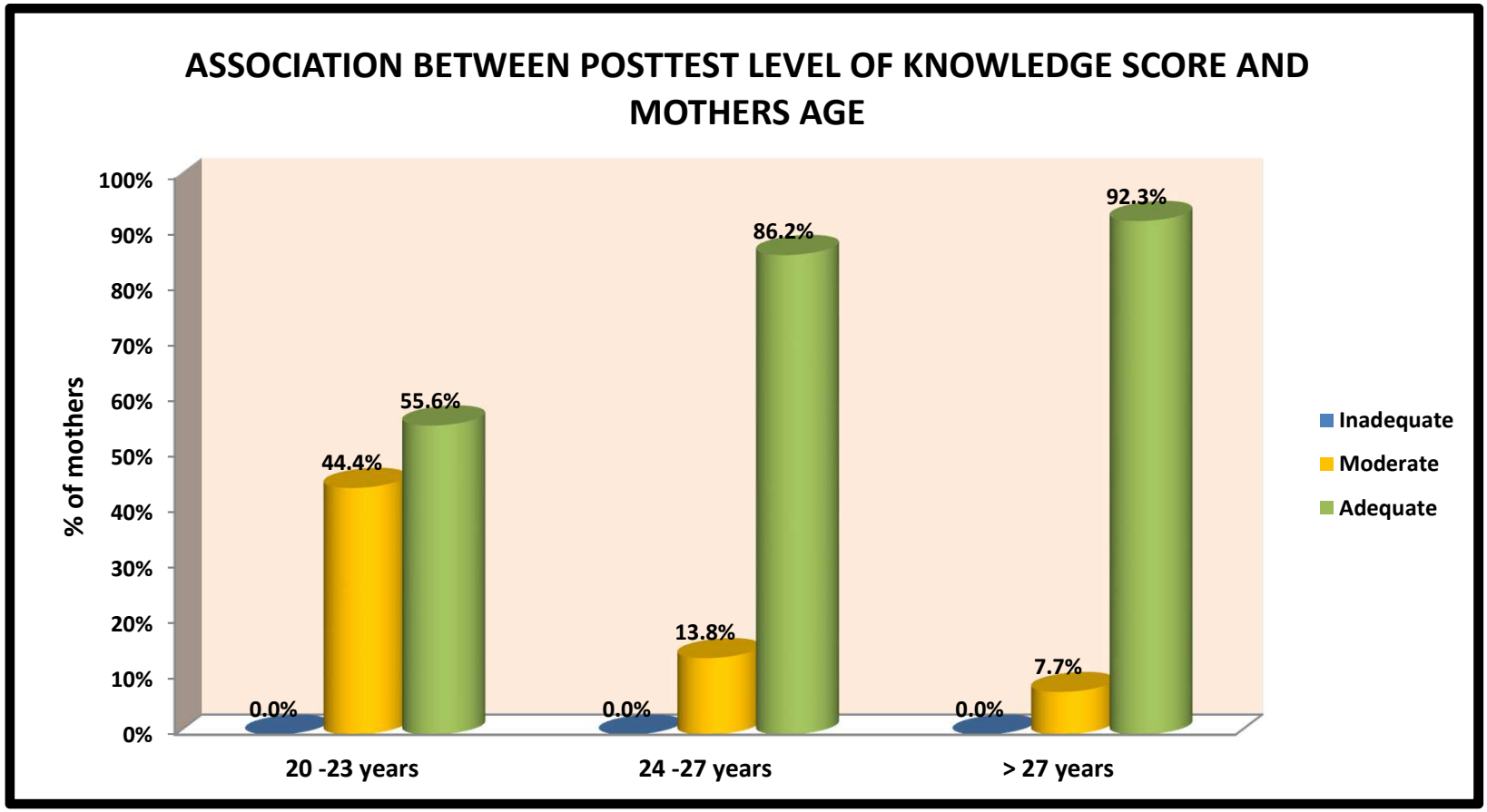

Fig. 4.19. Association between posttest level of knowledge score and mothers age

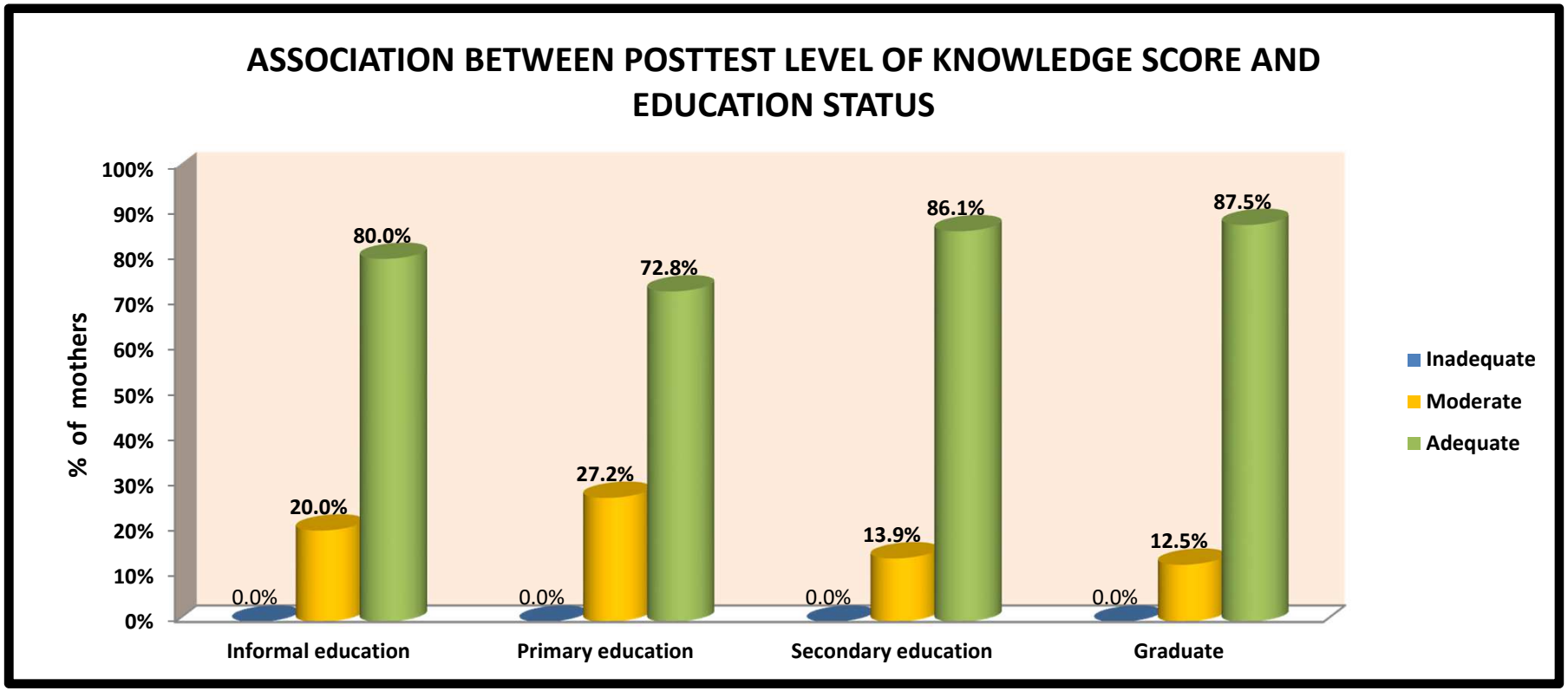

Fig.4.20. Association between posttest level of knowledge score and education status

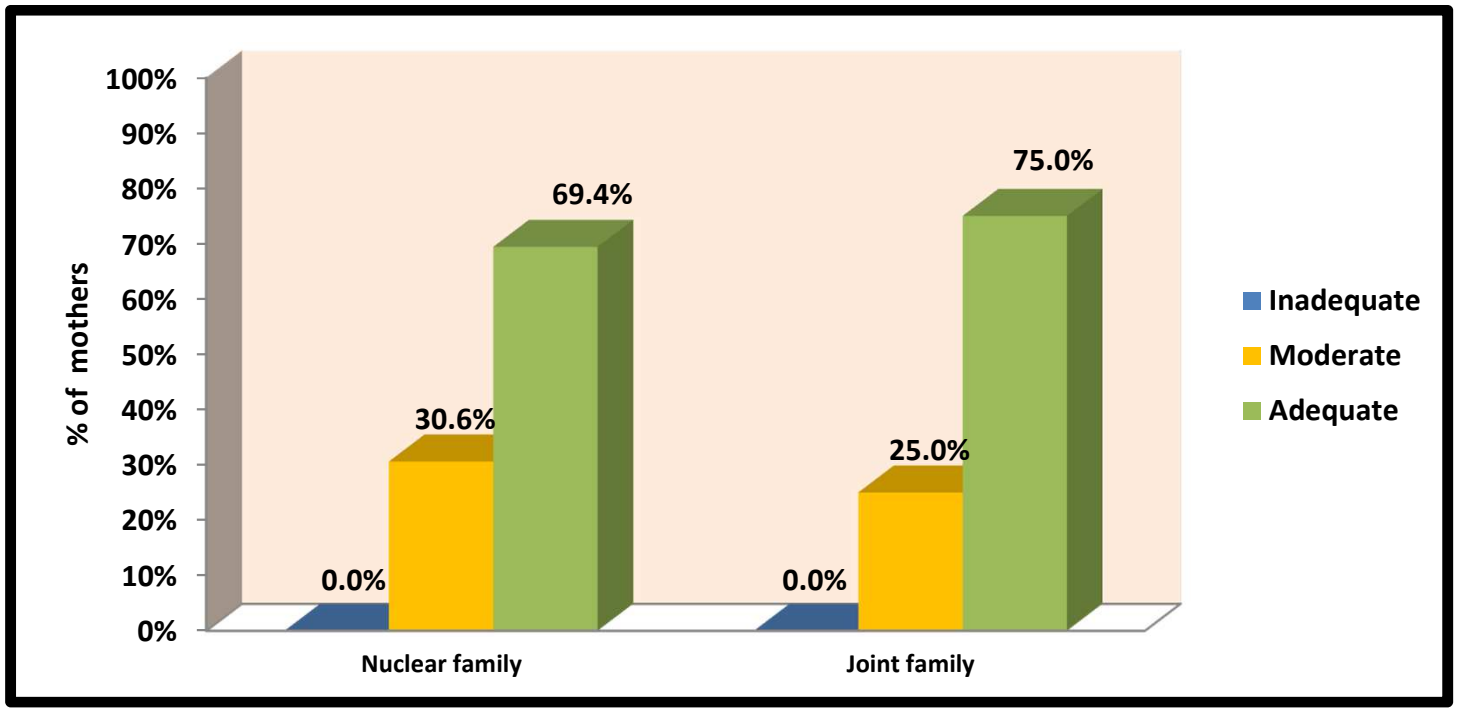

Fig. 4.21 : Association between post-test level of knowledge score and type of family system

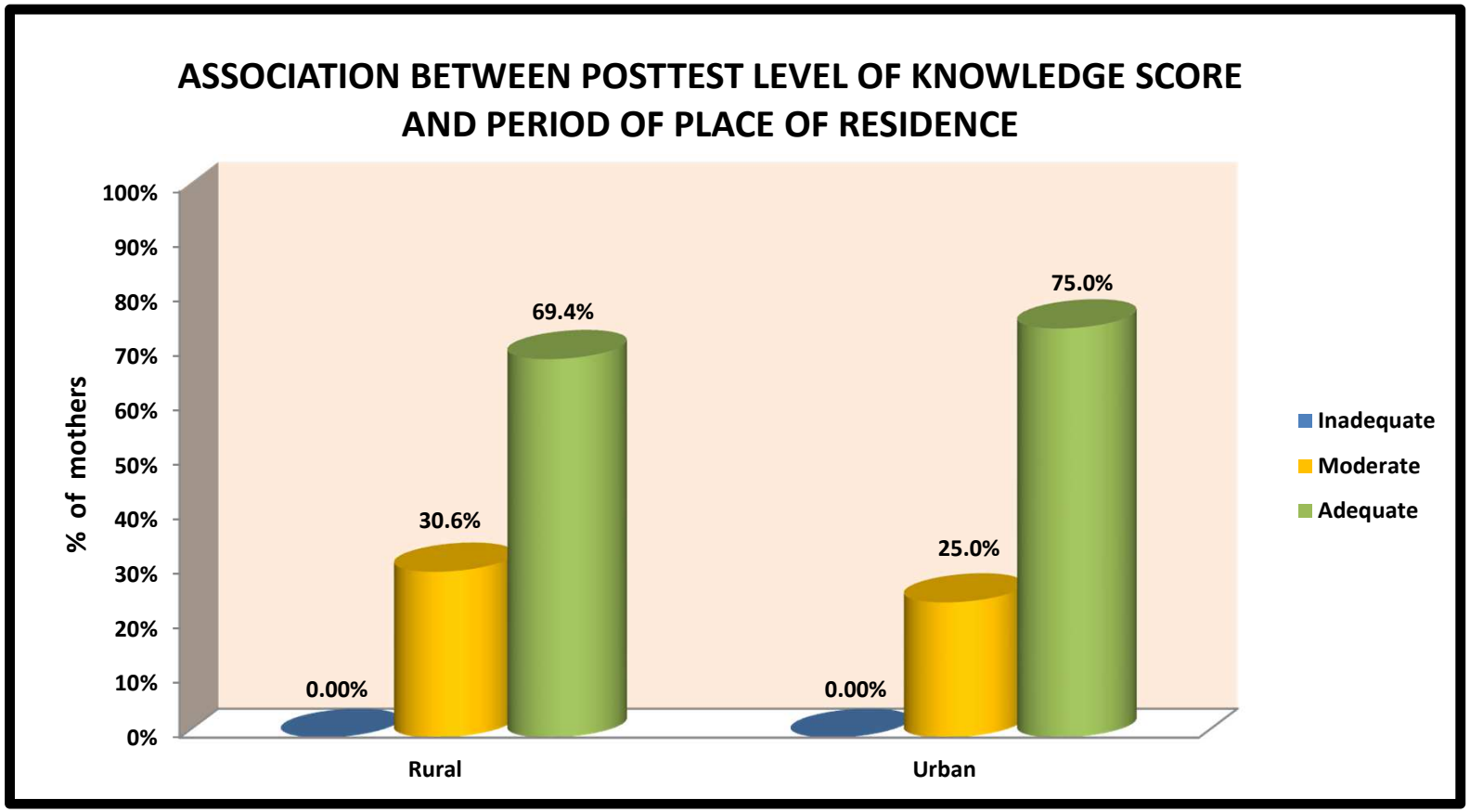

Fig.4.22: Association between post-test level of knowledge score and period of place of residence

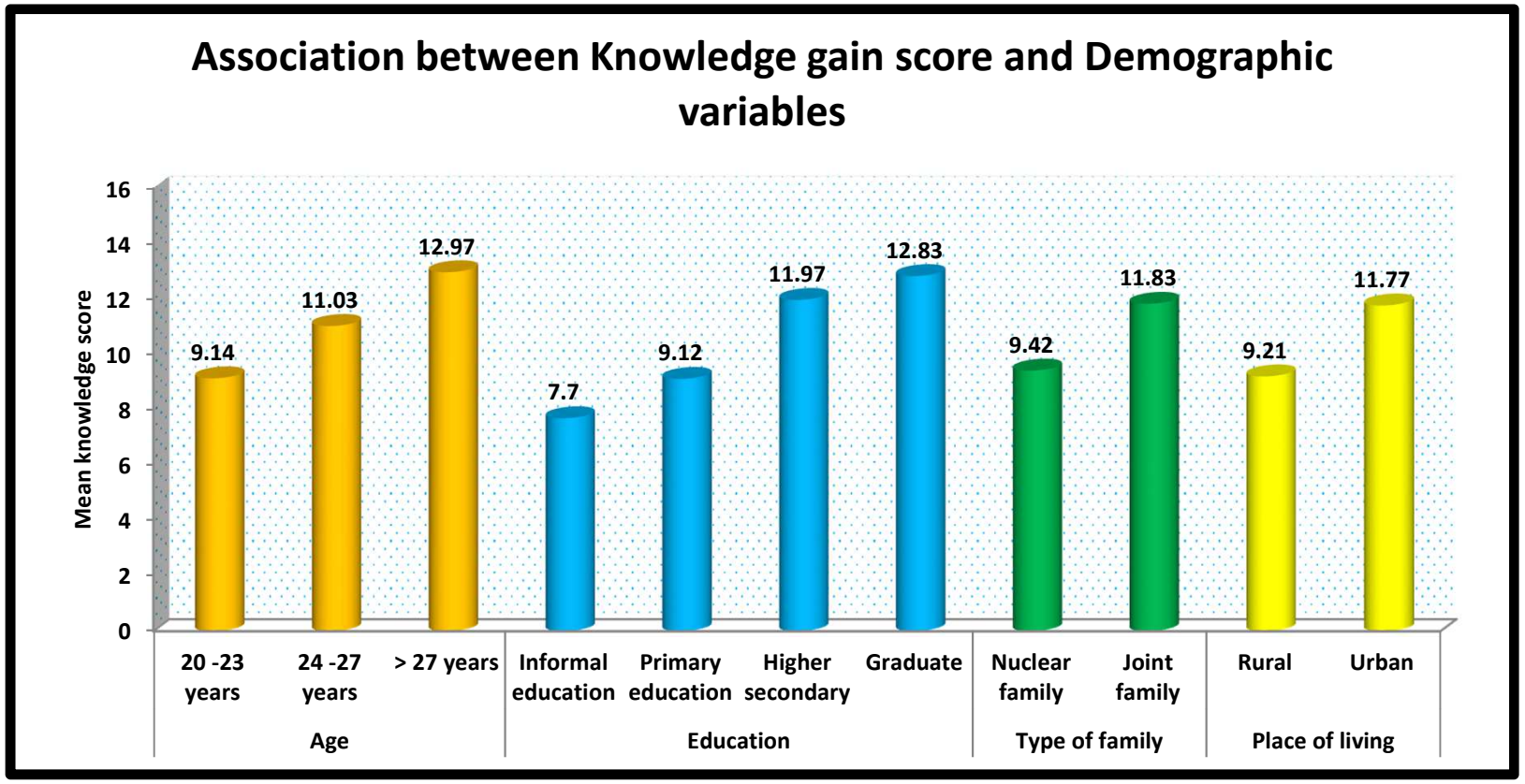

Fig.4.23 : Association between Knowledge gain score and Demographic variables

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INSTITUTIONAL ETHICS COMMITTEE
MADRAS MEDICAL COLLEGE, CHENNAI 600 003

EC Reg.No.ECR/270/Inst./TN/2013
Telephone No.044 25305301
Fax: 011 25363970

CERTIFICATE OF APPROVAL

To

S.Jayasutha
M.Sc. (N) I Year Student
College of Nursing
Madras Medical College
Chennai 600 003

Dear S.Jayasutha,

The Institutional Ethics Committee has considered your request and approved your study titled **"EFFECTIVENESS OF STRUCTURED TEACHING PROGRAMME ON KNOWLEDGE OF SELECTED POST OPERATIVE SELF CARE FOR PRIMI MOTHERS UNDERGOING ELECTIVE CESAREAN SECTION IN INSTITUTE OF OBSTETRICS AND GYNAECOLOGY AND GOVT. HOSPITAL FOR WOMEN AND CHILDREN, CHENNAI " - NO.35072017**

The following members of Ethics Committee were present in the meeting hold on **11.07.2017** conducted at Madras Medical College, Chennai 3

1. Prof.Dr.C.Rajendran, MD., :Chairperson
2. Prof.R.Narayana Babu,MD.,DCH.,Dean,MMC,Ch-3 : Deputy Chairperson
3. Prof.Sudha Seshayyan,MD., Vice Principal,MMC,Ch-3 :Member Secretary
4. Prof.S.Mayilvahanan,MD,Director,Inst. of Int.Med,MMC, Ch-3 : Member
5. Prof.A.Pandiya Raj,Director, Inst. of Gen.Surgery,MMC : Member
6. Prof.Rema Chandramohan,Prof.of Paediatrics,ICH,Chennai : Member
7. Prof. Susila, Director, Inst. of Pharmacology,MMC,Ch-3 : Member
8. Thiru S.Govindasamy, BA.,BL,High Court,Chennai : Lawyer
9. Tmt.Arnold Saulina, MA.,MSW., :Social Scientist
10. Tmt.J.Rajalakshmi, JAO,MMC, Ch-3 : Lay Person

We approve the proposal to be conducted in its presented form.

The Institutional Ethics Committee expects to be informed about the progress of the study and SAE occurring in the course of the study, any changes in the protocol and patients information/informed consent and asks to be provided a copy of the final report.

Member Secretary, Ethics Committee

MEMBER SECRETARY
INSTITUTIONAL ETHICS COMMITTEE
MADRAS MEDICAL COLLEGE
CHENNAI-600 003

REQUISITION LETTER

From

S. Jayasutha

M.sc (N) –II year student,

College of Nursing,

Madras Medical College, Chennai-3.

To

DIRECTOR AND SUPERINTENDENT

Institute of Obstetrics and Gynaecology and

Government Hospital for Women and Children,

Egmore, Chennai- 08.

Through,

PRINCIPAL,

College of Nursing, Madras Medical College,

Chennai – 03.

Respected Sir/Madam,

Sub: Requesting permission to conduct research for Dissertation as per requirement at Institute of Obstetrics and Gynaecology and Government Hospital for Women and Children Egmore, Chennai-08.

Forwarded.
6.12.17
for PRINCIPAL
COLLEGE OF NURSING
MADRAS MEDICAL COLLEGE
CHENNAI - 600 003.

I M.Sc Nursing II- year student has to conduct the research study for the fulfillment of MSc (N) programme. My topic is "**EFFECTIVENESS OF STRUCTERED TEACHING PROGRAMME ON KNOWLEDGE OF SELECTED POST OPERATIVE SELF CARE FOR PRIMI MOTHERS UNDER GOING ELECTIVE CESAREAN SECTION IN INSTITUTE OF OBSTETRICS AND GYNAECOLOGY AND GOVT HOSPITAL FOR WOMEN AND CHILDREN, CHENNAI- 8.**" The data collection period is from 02.01.2018 to 20.01.2018 between 8am - 4pm at antenatal ward in Institute of Obstetric and Gynaecology and Government Hospital for Women and Children Egmore, Chennai-08.

I request you to permit me to conduct the above study and I assure that I will not disturb the routine activities of the antenatal ward.

Thanking You

Signature of H.O.D

V. Vijaya
6-12-17

Permitted
21/12/17
Director and Superintendent
Institute of Obstetrics and Gynaecology
and Govt. Hospital for Women & Children
Egmore, Chennai-600 008.

Yours faithfully,

S. Jayasutha

(S. Jayasutha)

Encl: Copy of Institutional Ethics Committee Approval Letter.

CERTIFICATE OF CONTENT VALIDITY

This is to certify that the tool constructed by Mrs. S. Jayasutha (M.Sc Nursing) II year student College of Nursing, Madras Medical College which is to be used in her study titled, **"EFFECTIVENESS OF STRUCTURED TEACHING PROGRAMME ON KNOWLEDGE OF SELECTED POST OPERATIVE SELF CARE FOR PRIMI MOTHERS UNDERGOING ELECTIVE CAESAREAN SECTION IN INSTITUTE OF OBSTETRICS AND GYNAECOLOGY AND GOVERNMENT HOSPITAL FOR WOMEN AND CHILDREN, CHENNAI."** has been validated by the undersigned. The suggestions and modifications given by me will be incorporated by the investigator in concern with their respective guide .Then she can proceed to do the research.

Signature with seal

Name : DR. M. THANGAMANI

Designation : Sr. Asst Professor

Assistant Surgeon
I.O.G. & Government Hospital
For Women and Children
Egmore, Chennai-8.

CERTIFICATE OF CONTENT VALIDITY

This is to certify that the tool constructed by Mrs.S. Jayasutha M.Sc(Nursing), II year, College of Nursing, Madras Medical College which is to be used in her study titled, **"EFFECTIVENESS OF STRUCTURED TEACHING PROGRAMME ON KNOWLEDGE OF SELECTED POST OPERATIVE SELF CARE FOR PRIMI MOTHERS UNDER GOING ELECTIVE CAESAREAN SECTION IN INSTITUTE OF OBSTETRICS AND GYNAECOLOGY AND GOVT HOSPITAL FOR WOMEN AND CHILDREN, CHENNAI.** has been validated by the undersigned. The suggestions and modifications given by me will be incorporated by the investigator in concern with their respective guide .Then she can proceed to do the research.

Signature with seal

PROF. Dr. ROSALINE RACHEL, M.Sc., (N), Ph.D.,(N)
PRINCIPAL
MMM COLLEGE OF NURSING
No.131, SAKTHI NAGAR,
NOLAMBUR, CHENNAI - 600 095.

Name : DR. Roselin Rachel . MSc(N). Ph.D

Designation : Principal.

College : College of Nursing.
Madras Medical Mission.

Place : Chennai-95

Date : 2.1.18

CERTIFICATE OF CONTENT VALIDITY

This is to certify that the tool constructed by Mrs.S. Jayasutha M.Sc(Nursing), II year, College of Nursing, Madras Medical College which is to be used in her study titled, **"EFFECTIVENESS OF STRUCTURED TEACHING PROGRAMME ON KNOWLEDGE OF SELECTED POST OPERATIVE SELF CARE FOR PRIMI MOTHERS UNDER GOING ELECTIVE CAESAREAN SECTION IN INSTITUTE OF OBSTETRICS AND GYNAECOLOGY AND GOVT HOSPITAL FOR WOMEN AND CHILDREN, CHENNAI.** has been validated by the undersigned. The suggestions and modifications given by me will be incorporated by the investigator in concern with their respective guide .Then she can proceed to do the research.

S. J. Nal..

Signature with seal

Name : DR. Nalini Seeralan. MSC(N). Ph.D.

Designation : Principal.

College : College of Nursing
Sri Ramachandra Medical University
Porur.

PRINCIPAL
Sri Ramachandra College of Nursing
SRI RAMACHANDRA MEDICAL COLLEGE & RI (DU)
Porur, Chennai-600 116.

Place : Chennai - 116.

Date :

CERTIFICATE OF ENGLISH EDITING

This is to certify that the dissertation work topic,"**EFFECTIVENESS OF STRUCTURED TEACHING PROGRAMME ON KNOWLEDGE OF SELECTED POST OPERATIVE SELF CARE FOR PRIMI MOTHERS UNDERGOING ELECTIVE CAESAREAN SECTION IN INSTITUTE OF OBSTETRICS AND GYNAECOLOGY AND GOVERNMENT HOSPITAL FOR WOMEN AND CHILDREN, CHENNAI**".done by Mrs. S. Jayasutha, (M.Sc Nursing) II year student, College of Nursing, Madras Medical College is edited for English language appropriateness.

NAME : C.VIJAYAN

DESIGNATION : BT. ASST. ENGLISH

PLACE : GHS, Kesavaraja Kuppam

DATE : 22/6/18.

SIGNATURE WITH SEAL :

C.VIJAYAN B.A B.Ed
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PALLIPAT (TALUK)
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CERTIFICATE OF TAMIL EDITING

This is to certify that the dissertation work topic, "**EFFECTIVENESS OF STRUCTURED TEACHING PROGRAMME ON KNOWLEDGE OF SELECTED POST OPERATIVE SELF CARE FOR PRIMI MOTHERS UNDERGOING ELECTIVE CAESAREAN SECTION IN INSTITUTE OF OBSTETRICS AND GYNAECOLOGY AND GOVERNMENT HOSPITAL FOR WOMEN AND CHILDREN, CHENNAI**".done by Mrs. S. Jayasutha, (M.Sc Nursing) II year student, College of Nursing, Madras Medical College is edited for Tamil language appropriateness.

NAME : தி.ய. சம்பத்

DESIGNATION : தமிழாசிரியர்

PLACE : அரசு உயர்நிலைப்பள்ளி, கேசவராஜகுப்பம்,

DATE :

SIGNATURE WITH SEAL : 22/6/18

தி.ய. சம்பத், எம்.ஏ., பி.எட்..
தமிழாசிரியர்
அரசு உயர்நிலைப் பள்ளி,
கேசவராஜகுப்பம் - 631 208.
திருவள்ளூர் மாவட்டம்.

SEMI STRUCTURED INTERVIEW SCHEDULE

INSTRUMENT

PART-I, DEMOGRAPHIC VARIABLE

Sample:

Name:

Address:

1. Age:

a) 18-23years [ ]
b) 24-27 years [ ]
c) 28 above [ ]

2. Religion

a) Hindu [ ]
b) Christian [ ]
c) Muslim [ ]
d) Others [ ]

3. Education

a) Primary education [ ]
b) Higher Secondary education [ ]
c) Graduate [ ]
d) Informal education [ ]

4. Occupation

a) Self-employee [ ]
b) Government [ ]
c) Private [ ]
d) House wife [ ]

5 .Monthly income

a) >Rs.5,000 [ ]
b) RS5,000 -7000 [ ]
c) RS.7,000-12000 [ ]
d) > Rs.12000 [ ]

6. Type of family

a) Nuclear [ ]
b) Joint [ ]

7. Area of residence

a) Rural [ ]
b) Urban [ ]

OBSTETRICAL HISTORY

8. Age at menarche

a) 11-13 yrs [ ]
b) 14-16 yrs [ ]
c) 17-19 yrs [ ]

9. Age at marriage

a) 16-18 yrs [ ]
b) 19-21 yrs [ ]
c) 22-24 yrs [ ]
d) 25 and above [ ]

10. Place of antenatal visit

a) Hospital [ ]
b) PHC [ ]

11. Pregnancy was registered

a) Yes [ ]
b) No [ ]

12. Antenatal checkup done by

a) Doctor [ ]
b) Staff nurse [ ]
c) Village health nurse [ ]

SOURCE OF INFORMATION

a) Parents [ ]
b) Mass media [ ]
c) Health professional [ ]
d) No exposure [ ]

PART-II. GENERAL INFORMATION ON POST-NATAL CARE

1. The postpartum period is

a) 6 weeks following child birth [ ]
b) Immediately after child birth [ ]
c) During breast feeding period [ ]
d) Don't know [ ]

2. Self-care means

a) Hospital care [ ]
b) Taking care of self [ ]
c) Doing self-care with others help [ ]
d) Don't know [ ]

BREAST CARE

3. Breast milk can be fed to the baby immediately

a) After birth [ ]
b) After 24 hours [ ]
c) After mother gets relax [ ]
d) Don't know [ ]

4. Cleaning both breasts before feeding will prevent transmission of

a) Cross infection to newborn [ ]
b) Disease to new born [ ]
c) Nothing [ ]
d) Don't know [ ]

5. Before and after feeding the newborn, clean the breast with

a) Wet cloth and dry it [ ]
b) Only wet cloth [ ]
c) Only dry cloth [ ]
d) Don't know [ ]

6. Nipples should be washed with

a) Clean cloth [ ]
b) Cotton wipe [ ]
c) Clean water [ ]
d) Don’t know [ ]

7. Colostrum is rich in

a) Fats [ ]
b) Minerals [ ]
c) protein [ ]
d) Don’t know [ ]

8. During antenatal period, breast care importance is taught by

a) Health professionals [ ]
b) Mass media [ ]
c) Parents [ ]
d) Don’t know [ ]

PERINEAL CARE

9. Perineum should be cleaned,

a) From front to back [ ]
b) From back to front [ ]
c) Lateral side [ ]
d) Don’t know [ ]

10. Perineal pads used for perineal hygiene is

a) Clean dry cloth [ ]
b) Cotton cloth [ ]
c) Sanitary napkin [ ]
d) Don’t know [ ]

11. Lochia means

a) Pain [ ]
b) Discharge from uterus [ ]
c) Bad odour [ ]
d) Don’t know [ ]

12. Applying perineal pad is from

a) Centre towards front [ ]
b) Back to front [ ]
c) Front to back [ ]
d) Don’t know [ ]

NEW BORN CARE

13. The ideal period for giving bath to newborn is

a) Immediately after birth [ ]
b) After One week [ ]
c) After one month [ ]
d) Don’t know [ ]

14. If the cord stump is bleeding, mother should not

a) Apply any medications [ ]
b) Report to doctor [ ]
c) Tying another tie [ ]
d) Don’t know [ ]

15. For the newborn clean the eyes with

a) Water [ ]
b) Soap and water [ ]
c) Soft clean cloth [ ]
d) Don’t know [ ]

16. Always Clean the eyes from

a) Medial to lateral side [ ]
b) Lateral to medial side [ ]
c) Only lateral side [ ]
d) Don't know [ ]

17. Newborn infection transmission can be prevented by

a) Hand washing with clean water [ ]
b) Wearing gloves and handling baby [ ]
c) Hand washing with soap and water [ ]
d) Don't know [ ]

18. Hypothermia can be prevented in newborn by

a) Not wrapping the baby [ ]
b) Keeping baby in close physical contact with mother [ ]
c) Administering medications [ ]
d) Don't know [ ]

19. Colostrums, the thick yellowish milk should necessarily be given to baby because

a) It is nutritious [ ]
b) Nutritious &has natural immunity against infections [ ]
c) It prevents disease [ ]
d) Don't know [ ]

20. Along with the milk, weaning should be started at

a) 1 year [ ]
b) After 4months of age [ ]
c) 6 months [ ]
d) Don't know [ ]

21. After feeding, burping is needed &must for

a) Preventing infection [ ]
b) Easy digestion [ ]
c) Easy to sleep [ ]
d) Don't know [ ]

22. The mother should get enough rest and sleep as it

a) Helps to maintain breast milk production [ ]
b) Prevents infection [ ]
c) Postnatal exercise [ ]
d) Don't know [ ]

23. The main use of post-natal exercises are

a) Improving muscle tone [ ]
b) Preventing backache [ ]
c) Giving relaxation [ ]
d) Don't know [ ]

24. There so many exercises to follow during postnatal period, but initial exercise start with

a) Leg movements and breathing exercises [ ]
b) Knee- Rolling [ ]
c) Curl –up exercise [ ]
d) Don't know [ ]

25.The exercises may be continued for at least

a) 2 months [ ]
b) 3 months [ ]
c) 1 months [ ]
d) Don't know [ ]

26. The frequency of post natal exercise are

a) Once a day [ ]
b) Two to three times a day [ ]
c) Twice a day [ ]
d) Don't know [ ]

BIRTH CONTROL METHOD

27. The type of birth control methods are

a) Temporary [ ]
b) Permanent [ ]
c) Both [ ]
d) Don't know [ ]

28. Spacing methods are

a) Oral pills and IUD [ ]
b) Tubectomy [ ]
c) Laproscopic sterilization [ ]
d) Don't know [ ]

29. Health benefits of oral contraceptives are

a) Reducing cancer [ ]
b) High degree of efficacy in preventing pregnancy [ ]
c) Preventing cardio vascular disease [ ]
d) Don't know [ ]

30. Contra indications to use intra uterine device is

a) Chronic pelvic infection & also pregnancy [ ]

b) Breast feeding [ ]

c) Head ache & vomiting [ ]

d) Don’t know [ ]

Scoring key to the questionnaire

1	**a**
2	**b**
3	**a**
4	**a**
5	**a**
6	**c**
7	**b**
8	**a**
9	**a**
10	**c**
11	**b**
12	**c**
13	**c**
14	**a**
15	**b**

16	**a**
17	**b**
18	**a**
19	**c**
20	**b**
21	**c**
22	**b**
23	**b**
24	**c**
25	**b**
26	**c**
27	**a**
28	**a**
29	**a**
30	**b**

INFORMED CONSENT FORM

Title of the study: **"A study to assess the effectiveness of structured teaching programme on knowledge of selected post-operative self care for primi mothers undergoing elective caesarean section in Institute of Obstetrics and Gynaecology, and Govt. hospital for Women and Children, Egmore, Chennai-3".**

Name of the Participant:

I ---------- have read the information in this form (or it has been read to me). I was free to ask questions and they have been answered. As I hereby give my consent to include me as the participant in this study.

1. I have read and understood the consent form and the information provided to me.
2. I have had the consent document explained to me.
3. I have been explained about the nature of the study
4. I have been explained about my rights and responsibilities by the investigator
5. I am aware of the fact that I can opt out of the study at any time without having to give any reason and this will not affect my further treatment in the hospital.
6. I hereby give permission to the investigator to release the information obtained on my study to other team personnel, sponsors, Institution Ethics Committee and any person or agency required by law like Health Controller General of India, IEC. I understand that they are publicly presented.
7. I understand my identity will be kept confidential when the study is publicly presented.
8. I have had my questions answered to my satisfaction
9. I have decided to participate in the study.

I am aware that if I have any questions during this study, I should contact the investigator. By signing this consent form I attest that the information given in this document about the research on me has been clearly explained to me and understood by me. I will be given a copy of this consent document.

Name and Signature /thumb impression of the participant

Name---------- Signature ---------- Date ----------

Name and Signature of the investigator or representative obtaining consent:

Name---------- Signature---------- Date----------

INFORMATION TO PARTICIPANTS

Investigator : S. JAYASUTHA

Name of Participant :

Tittle: **"A study to assess the effectiveness of structured teaching programme on knowledge of selected post-operative self care for primi mothers undergoing elective caesarean section in Institute of Obstetrics and Gynaecology, and Govt. hospital for Women and Children, Egmore, Chennai-3".**

This study is conducted in Institute of Obstetrics and Gynecology, Egmore, Chennai-8. You are invited to take part in this study. The information in this document is meant to help you decide whether or not to take part. Please feel free to ask if you have queries or concerns.

What is the Purpose of the Research (explain briefly)

This Research is conducted to assess the effectiveness of structured teaching programme on knowledge of selected post-operative self care for primi mothers undergoing elective caesarean section. We have obtained permission from the Institutional Ethical Committee.

The Study Design

Pre experimental one group pre test – post test design.

Study Procedures

The study involves assessing the effectiveness of structured teaching programme on knowledge of selected post-operative self care for primi mothers undergoing elective caesarean section.

Possible Effects to You –

No risks involved

Possible benefits to you

After finishing this study, investigator will provide information that structured teaching programme increasing the knowledge of selected post-operative self care for primi mothers undergoing elective caesarean section

Possible benefits to other people

The result of the research may motivate the nurses to educate to others about post operative self care

CONFIDENTIALITY OF THE INFORMATION OBTAINED FROM YOU

You have the right to confidentiality regarding the privacy of your medical information (personal details, results of physical examination, investigation, and your medical history). By signing this document you will be allowing the research team investigators, other study personnel, sponsors, and any person or agency required by law like the Drug Controller General of India to view your data, if required. The information from this study, if published in scientific journals or presented at scientific meetings, will not reveal your identity.

HOW WILLYOUR DECISION NOT TO PARTICIPATE IN THE STUDY AFFECT YOU?

Your decisions not to participate in this research study will not affect your, medical care or your relationship with investigator or the institution.

CAN YOU DECIDE TO STOP PARTICIPATION IN THE STUDY ONCE YOU START?

The participation in this research is purely voluntary and you have the right to withdraw from this study at any time during course of the study without giving reasons. However, it is advisable that you talk to the research team prior to stopping the treatment.

Confidentiality of the information obtained from you

You have the right to confidentiality regarding the privacy of your medical information (personal details, results of physical examinations, investigations, and your medical history). By signing this document, you will be allowing the research team investigators, other study personnel, sponsors, IEC and any person or agency required by law like the Drug Controller General of India to view your data, if required. The information from this study, if published in scientific journals or presented at scientific meetings, will not reveal your identity.

How will your decision not to participate in the study affect you?

Your decisions not to participate in this research study will not affect your daily living activities, medical care or you relationship with investigator or the institution.

Can you decide to stop participating in the study once you start?

The participation in this research is purely voluntary and you have the right to withdraw from this study at any time during course of the study without giving any reasons.

However, it is advisable that you talk to the research team prior to stopping the treatment.

Signature of the Investigator

Signature of the mother with date